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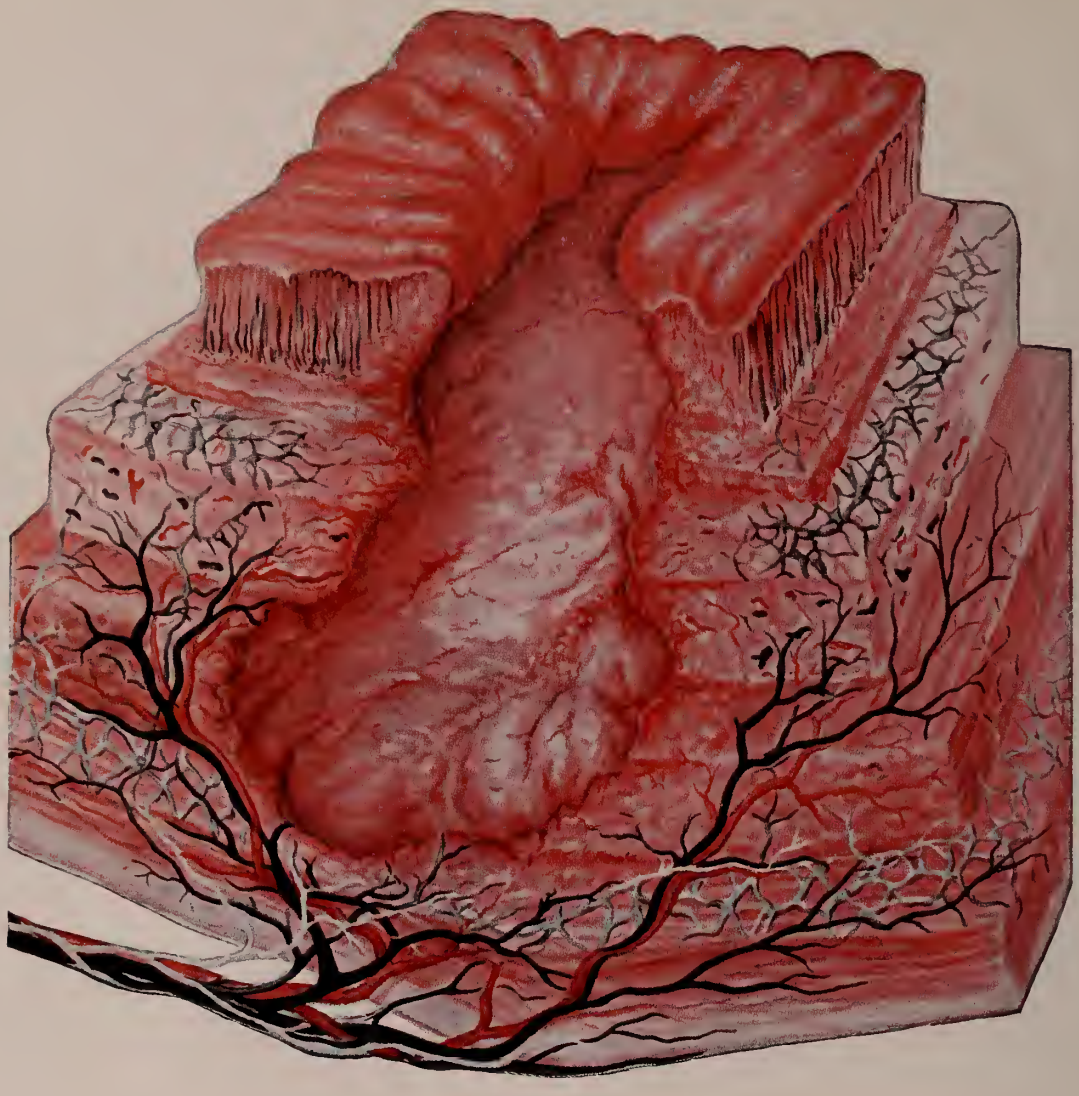
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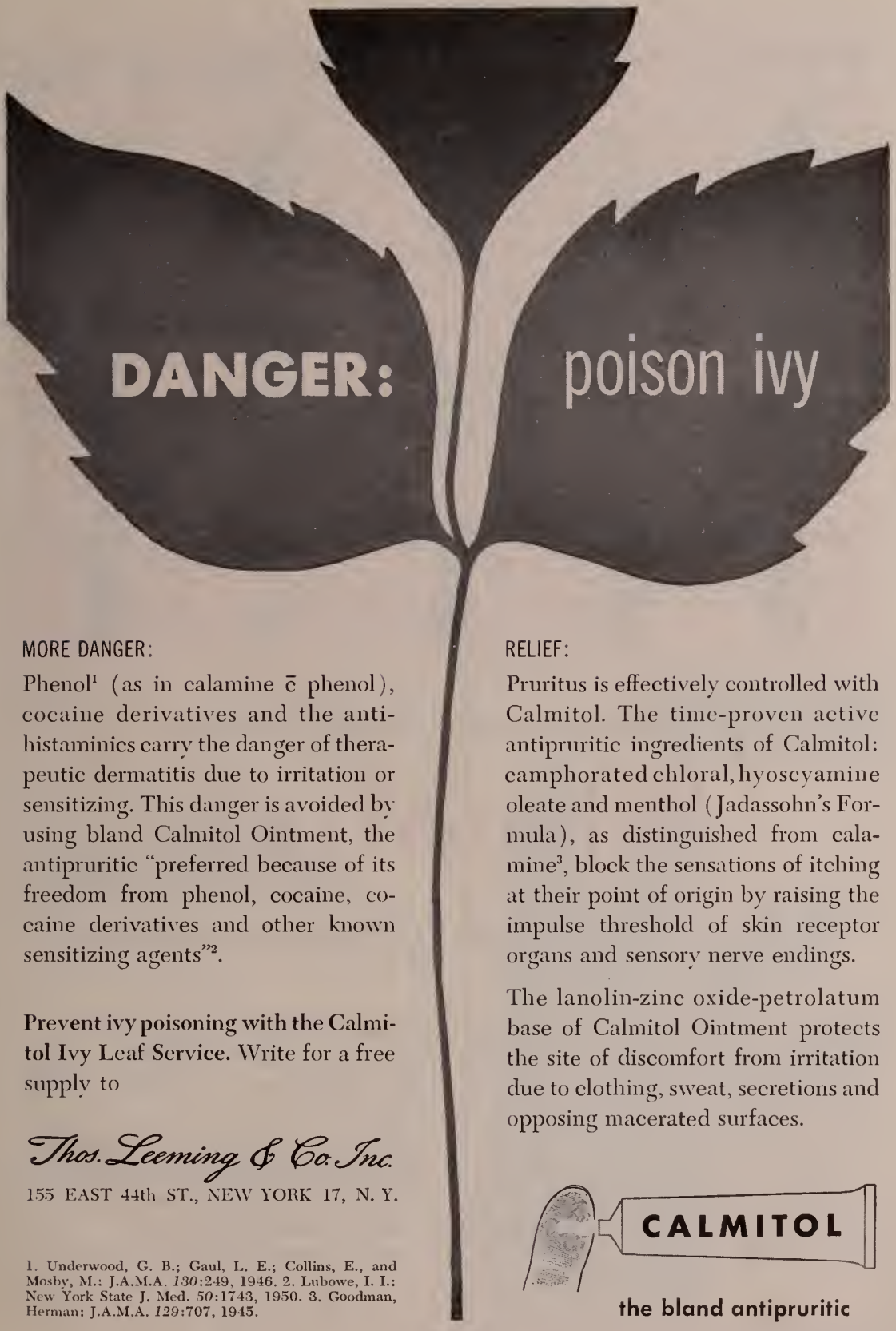
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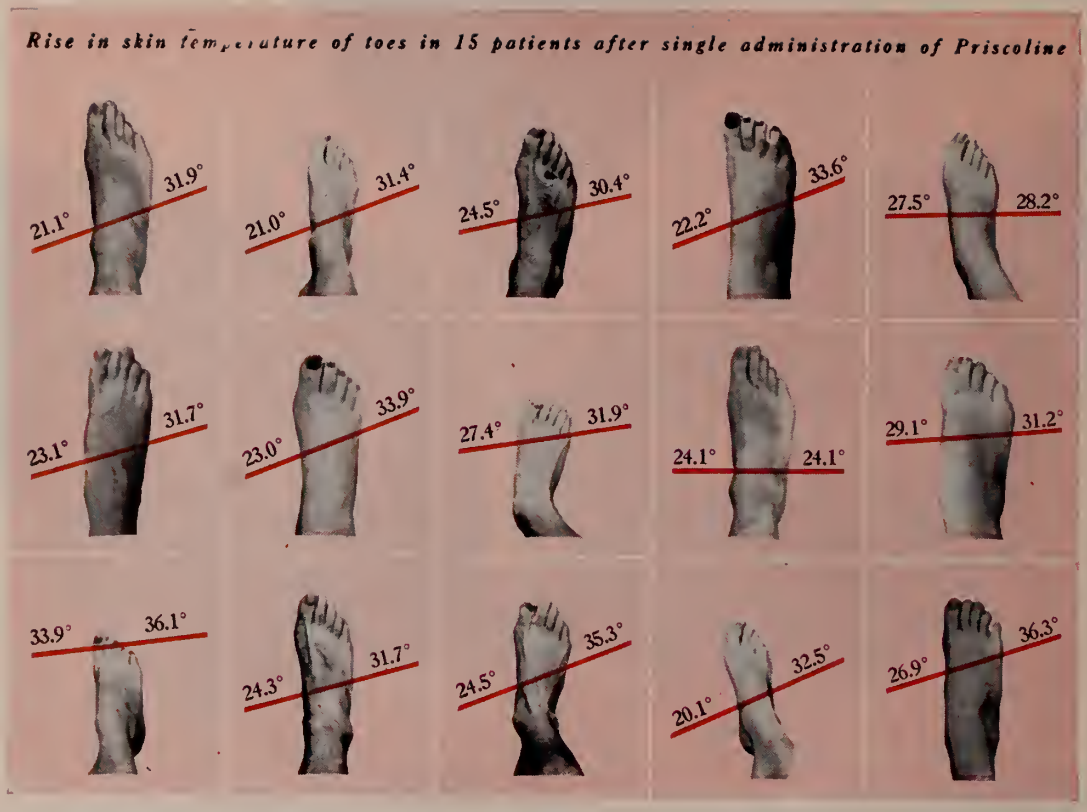
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1. Ready, W. J.: J. of Lab. & Clin. Med. 37:365 (March) 1951.

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1. Hock, C.W.: J. Med. Assn. Go. 40: Jan., 1951
2. Hufford, A.R.: J. Mich. St. Med. Soc. 49:1308, 1950
3. Chomberlin, D.T.: Gostroenterology 17: Feb., 1951

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Shelby	E. M. Montgomery, Shelbyville	H. C. Turney, Shelbyville
Stephenson	Victor V. Rockey, Freeport	John S. Clark Jr., Freeport
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Union	Harry Phillips, Anna	Wm. H. Whiting, Dongola
Vermilion	Oscar J. Michael, Danville	Donald L. Dickerson, Danville
Wabash	T. R. Young, Mt. Carmel	H. A. Elkins, Mt. Carmel
Warren	John Bohan, Alexis	Henry C. Scholer, Monmouth
Washington	P. B. Rabenneck, Nashville	Roscoe C. Vernor, Nashville
Wayne	Kenneth E. Hubble, Fairfield	Gilbert Ransom, Fairfield
White	J. Z. Stanley, Carmi	Charles Rosenberg, Norris City
Whiteside	G. J. Pohly, Rock Falls	D. M. Burnstine, Sterling
Will-Grundy	E. J. Viskocil, Lockport	D. H. Wehrspann, Joliet
Williamson	J. W. Tidwell, Herrin	Martin M. May, Marion
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Dilaudid hydrochloride

(dihydromorphinone hydrochloride)

COUNCIL ACCEPTED



Powerful opiate analgesic - dose, 1/32 grain to 1/20 grain.

Potent cough sedative - dose, 1/128 grain to 1/64 grain.

Readily soluble, quick acting.

Side effects, such as nausea and constipation, seem less likely to occur.

An opiate, has addictive properties.

Dependable for relief of pain and cough, not administered for hypnosis.

● Dilaudid is subject to Federal narcotic regulations. Dilaudid, Trade Mark Bilhuber.

Bilhuber-Knoll Corp. Orange, N. J.

more effective against



tinea capitis

"More effective in ringworm of the scalp than any other topical agent."[1]



tinea pedis

In "athlete's foot" a combined cured and improved rate of 95% has been obtained.[1]

Also indicated in

tinea corporis
tinea cruris
tinea versicolor
tinea of the nails

"broad antifungal spectrum ...good cutaneous tolerance."[1]

New!

Asterol® *dihydrochloride*

5% tincture . . . ointment . . . powder . . .
sprayed, applied with cotton or dusted on

'Roche'

1. Stritzler, C.; Fishman, I. M., and Laurens, S.: *Transactions New York Acad. Sc., 13*:31, Nov., 1950.

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ASTEROL DIHYDROCHLORIDE 'ROCHE'—BRAND OF DIAMTHAZOLE DIHYDROCHLORIDE [2-DIMETHYLAMINO-6-(β-DIETHYLAMINO ETHOXY)-BENZOTHIAZOLE DIHYDROCHLORIDE]

THE
OUTSTA
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PREPAR

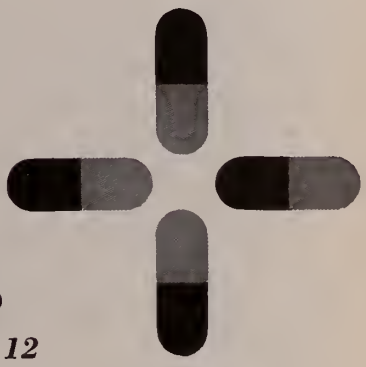
Feosol Tablets

he standard iron therapy

Feosol Elixir

he standard liquid iron

Feosol Plus *now contains* B_{12}



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Smith, Kline & French Laboratories, Philadelphia

'Feosol' & 'Feosol Plus' T.M. Reg. U.S. Pat. Off.

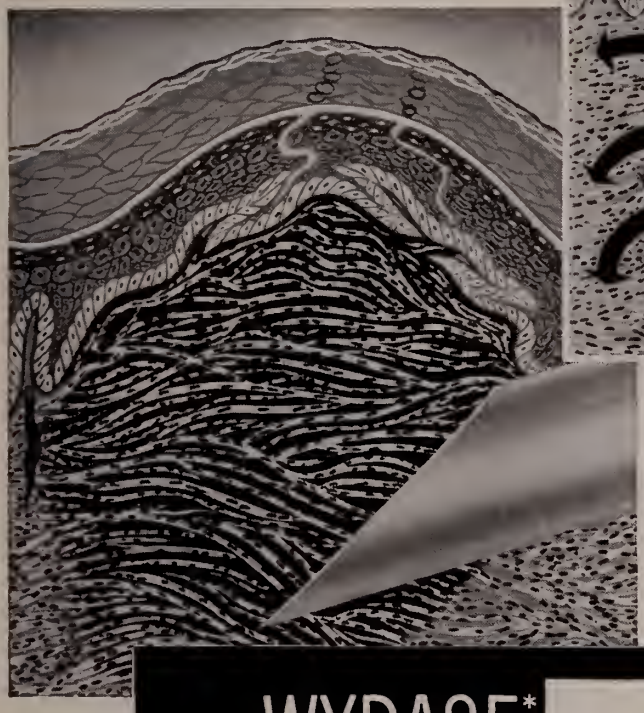
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relief of
bronchial
asthma
orthoxine
hydrochloride
The bronchodilating, antispasmodic and decongestive effects of Orthoxine* Hydrochloride [beta- (orthomethoxyphenyl) - isopropyl-methylamine hydrochloride] are useful in the treatment of bronchial asthma. In usual therapeutic and prophylactic doses Orthoxine Hydrochloride exerts minimal vasopressor, cardiac and central nervous system side effects.
Supplied in 100 mg. scored tablets in bottles of 100 and 500.
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Upjohn
Medicine... Produced with care... Designed for health
THE UPJOHN COMPANY, KALAMAZOO 99, MICHIGAN

HYPODERMOCLYSIS

with WYDASE





without WYDASE

WYDASE*

(formerly Hydase)

Lyophilized Hyaluronidase

Wyeth®

Highly Purified

For speedy absorption of fluids in hypodermoclysis. Prevents pain from stretching of tissue—nontoxic and apparently nonallergenic.

For More Complete and Widespread Local Anesthesia—fewer injections of local anesthetics required.

WYDASE in dry form is stable indefinitely; keeps in sterile solution for 2 weeks—refrigeration unnecessary.

SUPPLIED: Vials of 150 and 500 turbidity reducing (TR) units.

*Trade Mark

Wyeth Incorporated . Philadelphia 2, Pa.


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from "intractable" asthma

The unique blocking action of ACTHAR against complex manifestations of hypersensitivity has been well-established. For the patient with severe, intractable asthma, ACTHAR produces most gratifying results; the threat of asthmatic attacks can be minimized.

Status asthmaticus which has defied all other therapeutic attempts may yield quickly to relatively small doses of ACTHAR.

Definite and often dramatic improvement of the patient makes ACTHAR therapy a truly economic measure in the difficult management of severe asthma.

ACTHAR Dosage.—***Initial Dose:*** Less severe cases, 12.5 mg. q. 6 h. Severe, chronic cases, including status asthmaticus, may require up to 25 mg. q. 6 h. The initial dose should be continued from 2 to 4 days or longer in severe cases. ***Tapering of Dose:*** When symptoms have been controlled, decrease dosage 5 mg. per injection every other day until a total of 10 to 12 days of therapy has been given. ***Maintenance Therapy:*** May be required in severe, chronic asthma; 10 to 20 mg. once or twice per day

Literature and directions for administration of ACTHAR, including contraindications, available on request.

ACTHAR is available in vials of 10, 15, 25 and 40 I.U. (mg.) The Armour Standard of ACTHAR is now accepted as the International Unit; 1 International Unit is identical with 1 milligram of ACTHAR.

ACTHAR

THE ARMOUR LABORATORIES BRAND OF ADRENOCORTICOTROPIC HORMONE (A.C.T.H.)

THE ARMOUR LABORATORIES

CHICAGO 11, ILLINOIS

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

B_{12} (EMF)

believed to be APF; may also be "HGF"

Evidence has been accumulated to suggest that vitamin B_{12}—now generally acknowledged to be the pure erythrocyte-maturing factor (*EMF*) or anti-pernicious-anemia (*APA*) factor—may well be identical with animal protein factor (*APF*). APF has been found to be essential for normal growth, and probably for the maintenance of life, in many animal species including chickens, pigs, rats, and mice.

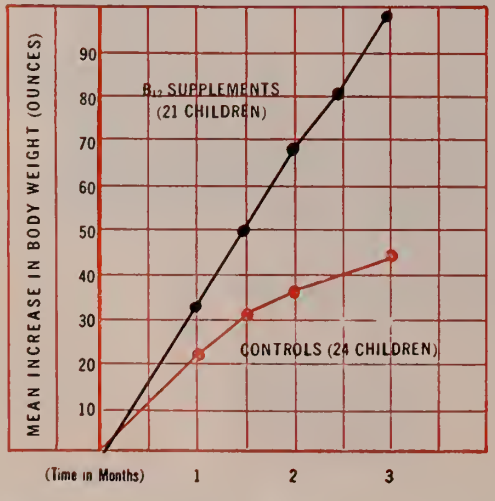
Now there is evidence to suggest that vitamin B_{12} is, or contains, an important human growth factor, or "*HGF*".

Wetzel and his associates[1] found that undernourished children grew much more rapidly on a good diet if vitamin B_{12} was also administered. *Chow*[2] found that in a group of chronically ill children, the experimental group (children who received vitamin B_{12} in addition to a good diet) exhibited a mean gain in body weight practically twice that of the control group (children who received a good diet—without supplementary vitamin B_{12}). This observation was made after three months' therapy with vitamin B_{12}.

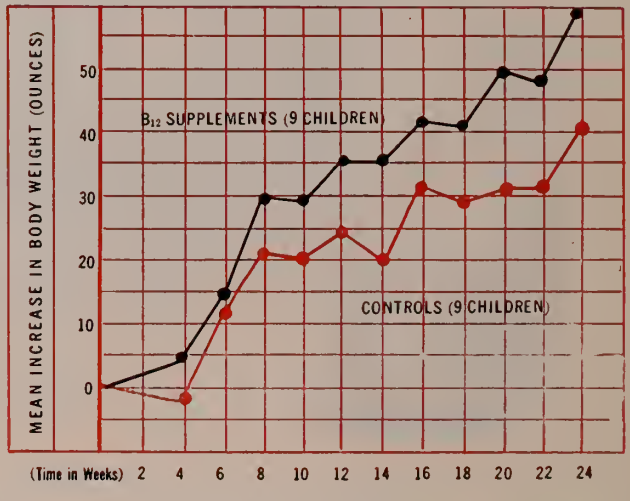
Chow[2] also reported on 18 healthy children in a foundling home. Nine of these children were each given a daily supplement of 25 micrograms of vitamin B_{12}; the other nine received placebos. It was found that the "mean gain in body weight of the children in the B_{12} group was consistently greater than that of the controls from the 4th week onward . . . "[2]

REDISOL® Tablets provide a convenient oral dosage form of vitamin B_{12}. Each tablet contains 25 micrograms of crystalline vitamin B_{12}. REDISOL Tablets are small—easy to swallow. They may be dissolved in aqueous fluids, or added to semisolid foods, just before taking. (Solutions of vitamin B_{12} lose potency if vitamin C is present.)

Growth response in chronically ill children. (After Chow[2])



Growth response in clinically healthy children. (After Chow[2])





Recent nutritional studies on children indicate that vitamin B_{12} may play an important role in the promotion of growth.

Recommended Dose

to stimulate appetite and increase voluntary food intake in infants and children: 1 tablet daily.

for pernicious anemia (maintenance therapy only): 1 to 6 tablets daily.

for nutritional macrocytic anemia and macrocytic anemia of pregnancy: 2 to 4 tablets daily for one week.

for sprue: 2 to 10 tablets daily for one week or longer, depending on response.

Packaging

REDISOL Tablets are supplied in vials of 36.

1. Wetzel, N. C.; Fargo, W. C.; Smith, I. H., and Heliksson, J.: Growth Failure in School Children as Associated with Vitamin B_{12} Deficiency—Response to Oral Therapy, Science *110*:651 (Dec. 16) 1949.
2. Chow, B. F.: Sequelae to the Administration of Vitamin B_{12} in Humans, J. Nutrition *43*:323, Feb. 1951.

Sharp & Dohme • Philadelphia 1, Pa.

REDISOL®

Soluble Tablets Vitamin B_{12} For Oral Administration



Beauty with brains

Your patients probably won't see beyond the sleek, blond mahogany and smooth styling of this modern beauty. But you'll appreciate the qualities hidden from view in the compact cabinet.

Consider its remarkable accuracy. In continuous recordings — one foot or fifty, there's never the slightest functional variation.

More than this, the Cardioscribe provides wide diagnostic range by facilitating the application of the following combinations of patient leads:

1, 2, 3 — Standard Extremity Leads
aVR, aVF, aVL — Augmented Unipolar Extremity Leads (Goldberger)
VR, VF, VL — Unipolar Extremity Leads (Wilson)
V (1 to 6 incl.) — Unipolar Chest Leads

Seven push-button controls make it possible to automatically select any of the above leads. More, there's no necessity for any change in the patient's electrodes other than that of properly positioning the exploratory electrode when unipolar extremity leads or unipolar chest leads are employed.

See your GE x-ray representative for a demonstration, or write



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pregnancy
threatened

PROLUTON® • **PRANONE®**
(Progesterone U.S.P.) (Ethisterone U.S.P.)



pregnancy
preserved

mainstay in the active treatment
of threatened abortion, PROLUTON, pure progesterone
for intramuscular injection, should be administered
in adequate dosage, promptly and frequently until symptoms subside.
Thereafter, a smooth course is favored by continuing
to provide action of the corpus luteum hormone with PRANONE,
orally effective anhydrohydroxyprogesterone.

Schering CORPORATION
BLOOMFIELD, NEW JERSEY

PROLUTON PRANONE

the man wh





• **Notably pleasing in taste and texture,** Robalate tablets are available sealed in transparent tape and packaged in boxes of 100; or in bulk in bottles of 500.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

ACCEPTED BY THE COUNCIL ON PHARMACY A

A smooth therapeutic course for *levelops ULCER*

Only by thwarting, somehow, the strong natural forces that normally repair lesions of gastric and duodenal mucosa, has the patient developed ulcer. Only by enlisting and implementing those forces effectively can ulcer be corrected. As an efficient antacid and demulcent, Robalate helps accomplish this with *no acid rebound, no change in acid-base balance,* and *no toxicity*. Robalate provides prompt and prolonged reduction of acidity, a rapid relief from pain. It covers the ulcer and the mucosa with a soft protective coating that favors restoration of normal function and healing. By *helping the ulcer help itself,* Robalate provides a smooth therapeutic course for the ulcer patient.

A. H. ROBINS COMPANY, INC.
Richmond 20, Virginia

BLETS Robalate®

(Dihydroxy aluminum aminoacetate, N.N.R., 0.5 Gm. per tablet)

1 Robins

EMISTRY OF THE AMERICAN MEDICAL ASSOCIATION



The only broad-spectrum antibiotic available in concentrated drop-dose potency, Crystalline Terramycin Hydrochloride Oral Drops provide 200 mg. per cc.; 50 mg. in each 9 drops. Indicated in a wide range of infectious diseases, Terramycin Oral Drops are miscible with most foods, milk and fruit juices, affording optimal ease and simplicity in administration.

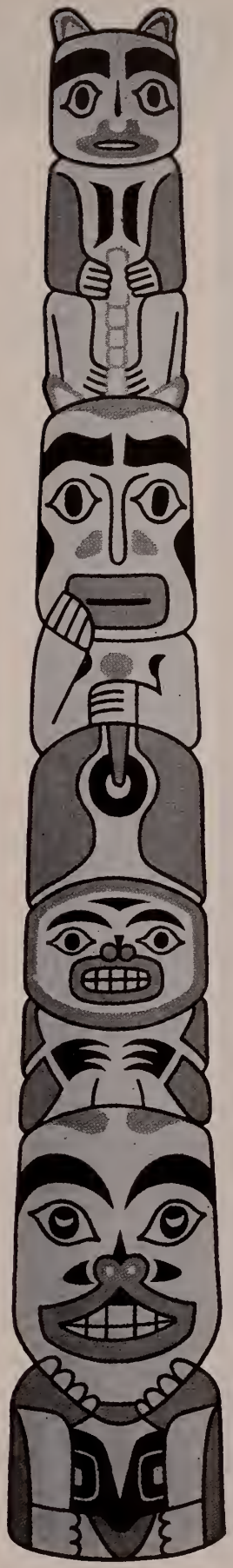
Supplied — *2.0 Gm. with 10 cc. of diluent, and calibrated dropper.*

ANTIBIOTIC DIVISION **Pfizer** CHAS. PFIZER & CO., INC., *Brooklyn 6, N. Y.*

TWOFOLD RELIEF OF NASAL CONGESTION in Colds and Allergic Rhinitis

NEO-SYNEPHRINE® THENFADIL®

Nasal Solution



Combines the prompt, prolonged nasal decongestant, Neo-Synephrine hydrochloride, and Thenfadil, a potent and well tolerated antihistaminic.

Tests by otorhinolaryngologists on patients with colds, allergic rhinitis, vasomotor rhinitis and sinusitis yielded excellent results in nearly all cases. There was prompt, prolonged decongestion without compensatory vasodilatation. Repeated doses were consistently effective. Relief was rapid with negligible discomfort, no drowsiness or other side effects.

Dose: 2 or 3 drops up to ½ dropperful three or four times daily. Solution contains 0.25% Neo-Synephrine HCl and 0.1% Thenfadil HCl [N,N-dimethyl-N′-(3-thenyl)-N′-(2-pyridyl) ethylenediamine HCl] in an isotonic buffered aqueous vehicle.

Supplied in bottles of 30cc. (1 fl. oz.) with dropper.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Neo-Synephrine and Thenfadil, trademarks reg. U. S. and Canada



for the gap between...

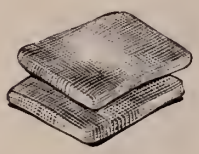
OXYCEL®

(OXIDIZED CELLULOSE)

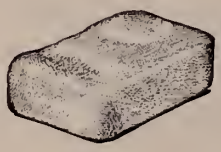
In the control of bleeding between arterial and venous systems, where vessel size precludes the use of hemostat and suture, OXYCEL—absorbable hemostatic—provides prompt control of capillary bleeding. Trauma is minimized, operative procedures shortened, and post-operative hemorrhage notably curtailed. OXYCEL is practical and convenient, too . . . applied direct from the container, it conforms readily to all wound surfaces.

Package Information:

Supplied in individual glass containers in the following convenient forms:



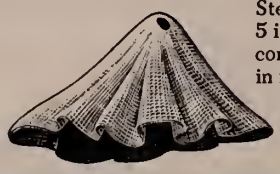
OXYCEL PADS:
Sterile, gauze-type,
3 inch x 3 inch
eight-ply pads,
and 4 inch x 12 inch
eight-ply pads.



OXYCEL PLEDGETS:
Sterile, cotton-type
2¼ inch x 1 inch x 1 inch portions.



OXYCEL STRIPS:
Sterile, four-ply
gauze-type strips
18 inch x 2 inch;
four-ply, 5 inch x ½ inch;
and four-ply 36 inch x ½ inch,
pleated in accordion fashion.



OXYCEL FOLEY CONES:
Sterile, four-ply, gauze-type discs,
5 inch and 7 inch diameters,
conveniently folded
in radially fluted form.

MEDICAMENTA VERA

PARKE, DAVIS & COMPANY



For **HIGH** *Pollen Levels—*

HIGH

Antihistaminic Potency

Neo-Antergan is characterized by high antihistaminic potency—and a high index of safety. It affords prompt, safe, symptomatic relief to the allergic patient during distressing periods of high pollen levels.

Neo-Antergan is *available on prescription only*, and is advertised exclusively to the medical profession.

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Available in coated tablets of 25 mg. and 50 mg. in bottles of 100, 500, and 1,000.

The Physician's Product

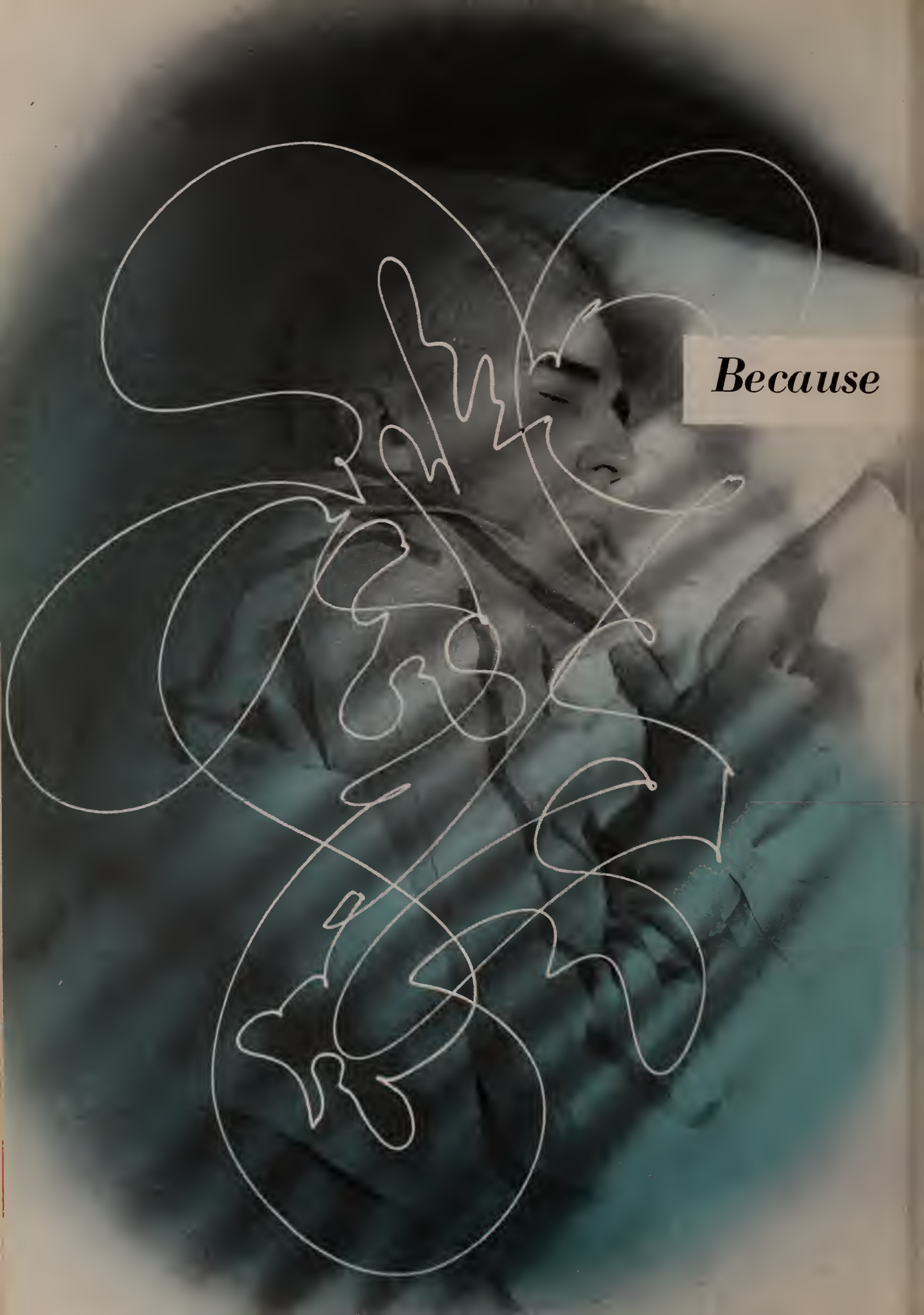
NEO-ANTERGAN®

MALEATE

(Brand of Pyrilamine Maleate)
(Formerly called Pyranisamine Maleate)

COUNCIL ACCEPTED

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RAHWAY, NEW JERSEY


Because

patients can't

"SLEEP OFF" *hypertension...*

prolonged vasodilation should accompany sleep as well as the day's activities. (One more reason why NITRANITOL is the most universally prescribed drug in the management of hypertension.)

NITRANITOL®

FOR GRADUAL, PROLONGED, SAFE VASODILATION

Merrell
1828
CINCINNATI • U.S.A.

When vasodilation alone is indicated. *Nitranitol.* (½ gr. mannitol hexanitrate.)

When sedation is desired. *Nitranitol with Phenobarbital.* (¼ gr. Phenobarbital combined with ½ gr. mannitol hexanitrate.)

For extra protection against hazards of capillary fragility. *Nitranitol with Phenobarbital and Rutin.* (Combines Rutin 20 mg. with above formula.)

When the threat of cardiac failure exists. *Nitranitol with Phenobarbital and Theophylline.* (½ gr. mannitol hexanitrate combined with ¼ gr. Phenobarbital and 1½ grs. Theophylline.)

Rx

In those difficult-to-control hypertensive patients

VERILOID*-VPM

VERILOID PHENOBARBITAL MANNITOL HEXANITRATE

Reduces the Incidence of Side Actions

When side actions have proved an obstacle to proper dosage adjustment, Veriloid-VPM usually makes possible continuation of therapy. Containing per tablet Veriloid, 2 mg., phenobarbital, 15 mg., and mannitol hexanitrate, 10 mg., Veriloid-VPM is indicated in all forms of hypertension regardless of severity. Blood pressure is reduced by the specific hypotensive properties of Veriloid—a distinctive biologically assayed fraction of Veratrum viride, the vasorelaxing action of mannitol hexanitrate, and the sedative influence of phenobarbital. This combination raises the nausea threshold, thus allowing many patients who have been found intolerant to Veriloid to benefit from Veriloid-VPM.

The average dose of Veriloid-VPM is one to one and one-half tablets four times daily, after meals and at bedtime. Detailed information available on request. Veriloid-VPM is supplied in bottles of 100, 500, and 1,000 scored tablets.

P.S.

For the physician who prefers plain Veriloid, this unique Veratrum fraction is available as usual in 1, 2, and 3 mg. scored tablets. Veriloid has produced outstanding results in hypertension of all degrees, lowering the blood pressure without loss of the postural reflexes so necessary for normal living.

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IN ALL DEGREES OF HYPERTENSION



relief!



the measure of a good hemorrhoidal suppository

ANUSOL* *HEMORRHOIDAL SUPPOSITORIES*

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Preferred and Prescribed by Physicians for more than half a Century.

ANUSOL* HEMORRHOIDAL SUPPOSITORIES promptly and effectively relieve the pain and discomfort of the common anorectal disorders.



ANUSOL* HEMORRHOIDAL SUPPOSITORIES do not contain narcotic or analgesic drugs which may mask more serious anorectal disorders.

For best results one ANUSOL* in the morning and at bedtime and immediately following each evacuation.

ANUSOL* HEMORRHOIDAL SUPPOSITORIES, individually foil wrapped, are available in boxes of 6, 12 and 48.

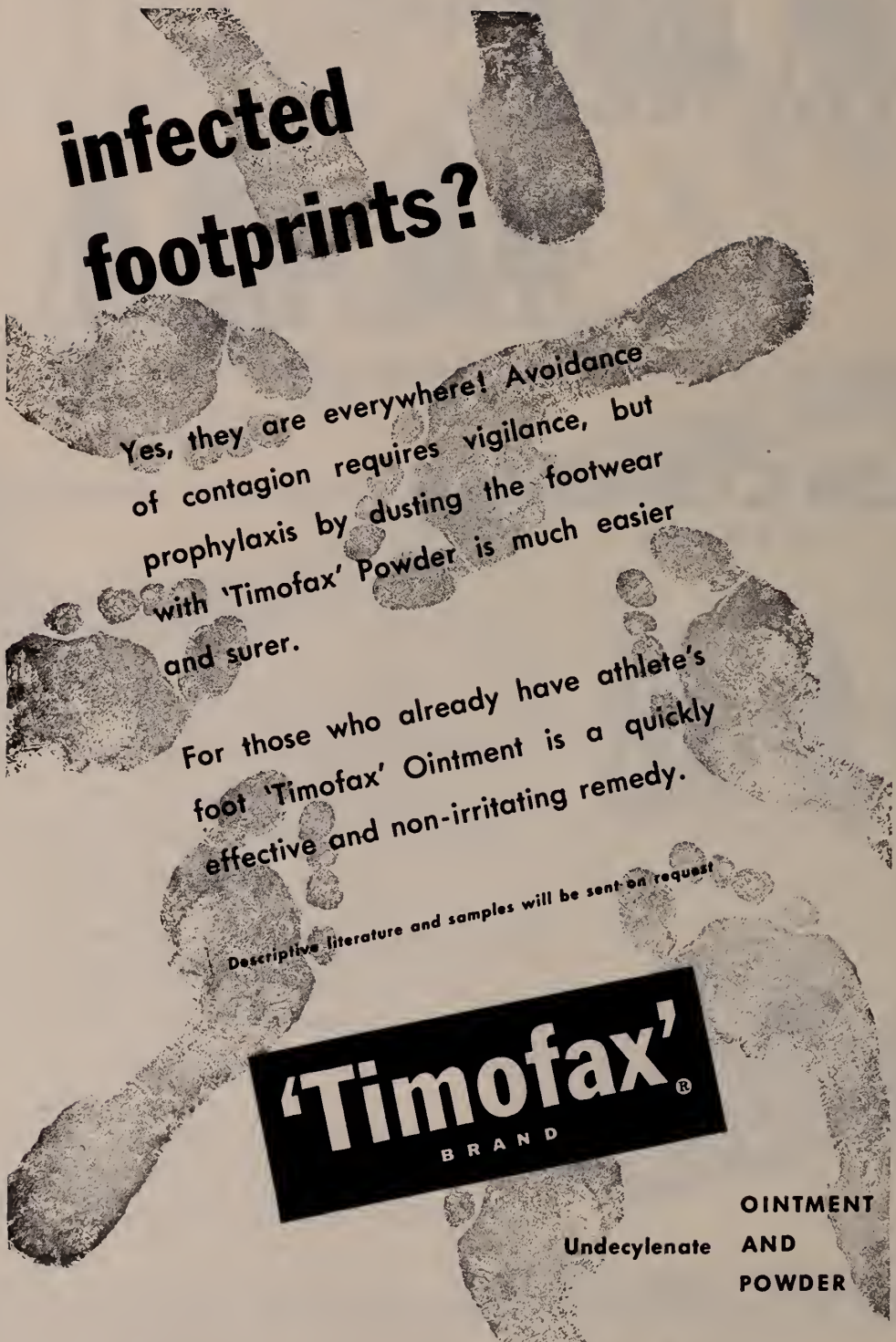
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WILLIAM R. WARNER

Division of Warner-Hudnut, Inc.

NEW YORK LOS ANGELES ST. LOUIS

*T. M. Reg. U. S. Pat. Off.


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Yes, they are everywhere! Avoidance of contagion requires vigilance, but prophylaxis by dusting the footwear with 'Timofax' Powder is much easier and surer.
For those who already have athlete's foot 'Timofax' Ointment is a quickly effective and non-irritating remedy.
Descriptive literature and samples will be sent on request
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for the first time
aqueous* multivitamin capsules

VI-AQUA

*oil-soluble vitamins (A-D-E) made water-soluble
... together with B complex vitamins and vitamin C

At last — after years of research — VI-AQUA provides the normally oil-soluble vitamins A, D and E in superior water-soluble form, together with B complex vitamins and ascorbic acid ... in capsules.



faster, more complete absorption
up to 400% higher blood levels with aqueous vitamin A

natural vitamin A
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well tolerated
fish liver taste and odor removed by special process

shorter treatment time, smaller dosage
because of more rapid, more complete absorption

Each **VI-AQUA** Capsule provides:

VITAMIN A* (natural)	5000 Units
VITAMIN D* (calciferol)	500 Units
THIAMINE HCl (B_1)	5 mg.
RIBOFLAVIN (B_2)	5 mg.
VITAMIN B_{12}	1 mcg.
NIACINAMIDE	20 mg.
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d, CALCIUM PANTOTHENATE	5 mg.
ASCORBIC ACID (C)	50 mg.
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*Oil soluble vitamins made water-soluble with sorethytan esters; protected by U. S. Patent 2,417,299.

Bottles of 50, 100, 500 and 1000 capsules

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Effective against many bacterial and rickettsial infections, as well as certain protozoal and large viral diseases.

AUREOMYCIN

Hydrochloride Crystalline



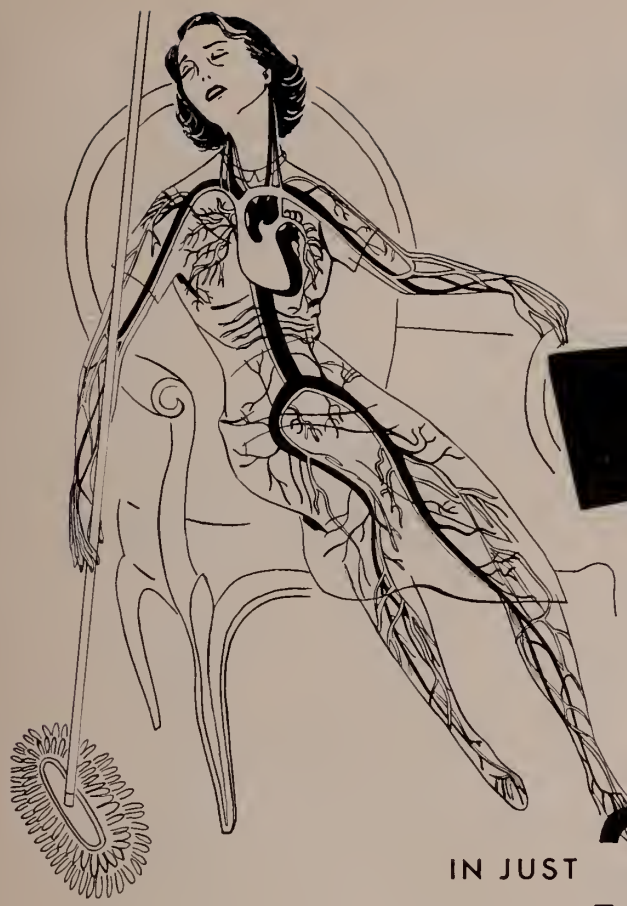
The Obstetrician

is daily finding aureomycin an increasingly valuable agent for the prevention and treatment of infection. It may be given to advantage prophylactically in long and difficult labors and in all operative deliveries or infected abortions. Aureomycin not only attacks the maternal disease but also, by its passage in therapeutic concentrations into the placental circulation, treats possible infection in the child before and during birth. Aureomycin has proved its usefulness in endometritis, parametritis, urinary infection, infected thrombophlebitis and other infections, caused by a wide variety of organisms. Aureomycin is a drug indispensable to obstetric practice.

Packages

Capsules: Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. distilled water.

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AMERICAN Cyanamid COMPANY
30 Rockefeller Plaza, New York 20, N. Y.



Really thorough Antianemic Therapy

IN JUST **3** TABLETS A DAY

Not just iron but iron *plus* B_{12}, folic acid, stomach-liver digest, other B vitamins and ascorbic acid. This is Iberol. Three tablets a day is the average therapeutic dose. Look at the formula. It is compounded on the basis that hemoglobin formation involves more than iron alone—that where iron deficiency is established other deficiencies are likely—that recovery may be more rapid and complete if all the important nutritional constituents are supplied to supplement the diet.

Prescribe it in any of the common microcytic anemias. Remember Iberol, too, in pregnancy, convalescence and old age. Iberol is stocked by pharmacies everywhere in bottles of 100, 500 and 1000 sugar-coated tablets.

Abbott

THREE IBEROL TABLETS

The average daily therapeutic dose for adults supplies:

Ferraus Sulfate (representing 210 mg. elemental iron, the active ingredient for the increase of hemoglobin in the treatment of iron-deficiency anemia)	1.05 Gm.
Plus these nutritianal canstituents:	
Thiamine Mononitrate (6 times MDR*)	6 mg.
Ribaflavin (3 times MDR*)	6 mg.
Nicotinamide (2 times RDA†)	30 mg.
Ascarbic Acid (5 times MDR*)	150 mg.
Pyridoxine Hydrochloride	3 mg.
Pantathenic Acid	6 mg.
Vitamin B_{12}	30 mcg.
Folic Acid	3.6 mg.
Stamach-Liver Digest	1.5 Gm.

*MDR—Minimum Daily Requirement.
†RDA—Recammended Daily Dietary Allawance.

SPECIFY **IBEROL®** tablets

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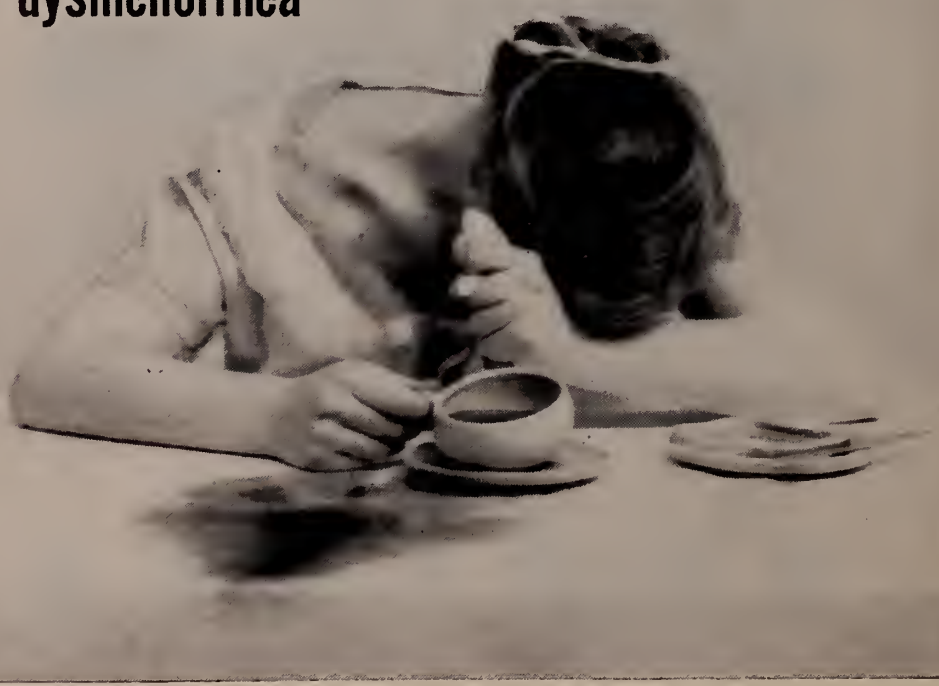
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The
ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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Vol. 100, No. 1 July, 1951

LET THE CHIPS FALL

Some of the patent medicine advertising in the newspapers and over television and radio is an insult to the intelligence of the average American. Not only is it a disgrace but this propaganda jeopardizes the repntation of everyone who deals with the welfare of the sick. Each day these ads grow larger and the claims more brazen as the advertisers do their best to hoodwink the public into buying vitamins, tonics, laxatives, minerals, hormones and antihistaminic products. Some of the selling campaigns have all the earmarks of a swindle; when the manufactnrer is told finally by the Government to "stop." he pockets his million, bids farewell to the suckers and politely leaves the scene.

Members of the drng industry also are concerned. Mr. L. F. Tice, Editor of the American Jonrnal of Pharmacy, recently wrote an editorial on this subject and stated that pharmacists have "again missed a great opportunity to give evidence of their sincerity of purpose and desire to be a full-fledged member of the public health team."

We assume that he refers to the recent experience with Hadacol when he continues as follows: "A product was recently offered the pnblic which every thinking pharmacist recognizes as a frank effort to capitalize on the credulity of the American pnblic. In advertising this product the owners would put the old-fashioned "medicine men" of the nineteenth century to shame. While the product is intrinsically harmless it is blatantly sold to the public at a price which is many times its true worth in comparison with many standard products containing essentially the same ingredients.

"Some pharmacists have refused to be a party in the sale of this product, recognizing that their obligation to both the public and the medical profession would make such participation impossible. Far too many others, operating on the principle, "Let the buyer beware," feel no compunction — not only in selling it but also in aiding and abetting such sale. The mute evidence of window and counter displays attest to this fact.

"There are many pharmacists who attempt to justify their attitude by pointing out that there are a number of established "over the counter" remedies which are in exactly the same category. This is indeed the case but most of these are products of a past era when self-medication was more widely accepted and drugs did not possess the potency and specificity of today's products. They are, furthermore, advertised with some restraint and not as the much sought after "Elixir of Life."

"For far too long pharmacists have been attempting to compromise professional integrity

with business acumen. At times both objectives are entirely compatible but, when they are not, the former always takes precedence. Those pharmacists who work diligently in promoting good professional relations with medicine, dentistry and nursing, and who give real thought to public health and welfare have every reason to resent the ill-advised actions of many of their fellow pharmacists. Just imagine the damage done to pharmacy's status when physicians see products of the type in question being advertised and sold by the very persons who clamor for better pharmacist-physician relations and who hail pharmacy as a health profession.

"Physicians, today, are utilizing the services of pharmacists more than ever before. Actually, in terms of dollars and cents the pharmacist often receives far more from the patient than does the attending physician. Pharmacists are not in dire economic straits and their prescription volume is better than it has been for years. There is surely no justification for encouraging the public to buy drug items which have little or no benefit and only add to the overall cost of medical care and leave less for real health needs."

Mr. Tice shares or sentiments and we sincerely hope that his efforts will bear fruit. There can be no doubt that the recent trend of events has strained the friendly relationship between the physician and pharmacists. It appears on the surface, at least, that many drug stores are more interested in selling these nostrums over the counter than compounding prescriptions. Integrity will finally solve this problem. The physician will select the pharmacist whose main interest is in serving the public rather than being an accomplice to the "patent medicine man."

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TRANSACTIONS OF THE HOUSE OF DELEGATES

The Illinois Medical Journal each year publishes the complete transactions of The House of Delegates during the annual meeting. In this issue of the Journal we are publishing the minutes of the first meeting of the House which met at the Hotel Sherman, Chicago, on Tuesday afternoon, May 22. The first meeting is principally devoted to a consideration of the many annual reports of officers, members of the Council, and committees. These are published in the handbook, a copy being sent to each member prior to the meeting.

Anyone presenting an annual report has the privilege of also submitting a supplementary report before the House of Delegates. The reports are referred to reference committees by the presiding officer of the House, hearings are held at which any member is permitted to discuss any matter presented in the reports, then the reference committee submits its report and recommendations to the House at its second meeting.

In addition to the annual reports, the first meeting of the House of Delegates also receives resolutions, and new business which are also referred to reference committees for study, and a report at the second meeting. The annual reports well present to the membership, the work of their Society during the past fiscal year. Every member should read the reports and become aware of what is being done in the State Medical Society.

Criticisms are frequently made relative to the work of individuals or committees, but unfortunately too often, those making them are not familiar with the facts, as presented in these annual reports.

The August issue of the Journal will present the actions of the second meeting of the House of Delegates, and report in detail the actions which were taken, and which likewise will be of great interest to members of the Illinois State Medical Society. There were a few changes in the By-Laws which will also appear in this section. During the summer, the Constitution and By-Laws will be revised and copies will be available for all component societies, officers, and other members desiring them.

Know your medical society and keep in touch with the many things the Society has been doing for the best interests of the membership as a whole.

ILLINOIS PHYSICIAN WINS AMERICAN HEART ASSOCIATION AWARDS

Gold Heart Awards for outstanding contributions in the field of heart and blood vessel disease and in furthering the program of the American Heart Association, were presented tonight at the Annual Dinner of the Association, at the

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Haddon Hall Hotel. Dr. Louis N. Katz, Chicago, newly-designated President of the Association, presented the Awards to Dr. James B. Herrick, Emeritus Professor of Medicine at the University of Chicago and the University of Illinois; Dr. Frank N. Wilson, Professor of Medicine, University of Michigan; and Dr. H. M. Marvin, Associate Clinical Professor of Medicine, Yale University.

In a citation describing the achievements of Dr. Herrick, Dr. Katz referred to him as "the most distinguished living student of the cardiovascular disorders." "As physician, scientific investigator and teacher," he said, "Dr. Herrick has made a classical contribution to our times. He is best known for his description of coronary thrombosis with myocardial infarction. His carefully documented reports led to general clinical recognition of this disorder and gave stimulus to this most important field of clinical cardiology." Dr. Herrick served as President of the American Heart Association in 1927. He helped organize, served as President, and is still Honorary President of the Chicago Heart Association.

THE 1952 ANNUAL MEETING

The House of Delegates at the 1951 annual meeting, voted unanimously to select the place and dates for meetings two years in advance. For the 1952 annual meeting, the Council was delegated the responsibility for selecting the place and dates, and likewise given authority for naming the place where the meeting will be held in 1953.

At the regular meeting of the Council held in Chicago on Sunday, June 3, the Council selected Chicago for the 1952 annual meeting, this to be held at the Hotel Sherman, and the date, May 13-15.

Although the exact place and date was not named, it was also unanimously voted to hold the 1953 annual meeting in Chicago. The time and place to be selected later this year. With the many present day requirements for a successful, annual meeting, it was found that no place in Illinois outside of Chicago is yet able to furnish adeqate facilities. It is hoped that some of the larger cities outside of Cook County will soon have a suitable auditorim or convention hall to make it possible to hold meetings of this type, and there are definite advantages in having more than one city with proper facilities for a successful meeting.

The attendance at the 1951 annual meeting was very satisfactory, and in addition to members from Illinois, there were many visitors from other states and physicians present from at least a dozen foreign countries. More information relative to the distribution of the physicians present, will be given in the August issue of the Illinois Medical Journal.

CORRESPONDENCE



"YOUR MENTAL HOSPITALS" PRIVATE INSTITUTIONS FOR MENTAL PATIENTS

There are 1151 approved beds for mental patients in the licensed private sanitaria, rest homes and psychiatric units of general hospitals in the State of Illinois.

Under the provisions of the Revised Mental Health Act, the Illinois Department of Public Welfare is responsible for the inspection and annual licensing of private mental institutions. According to the Statutes, no private sanitarium, rest home or hospital is permitted to accept mental patients and retain the patients, without consent, in the facilities in locked wards, unless the patients have been committed as "mentally ill" or "in need of mental treatment" or as a "voluntary" or temporarily as an "emergency."

In order to comply with the provisions of the law, the Department has set up certain standards for the private mental institutions. Inspections by the Department include determination of the adequacy of the trained, professional and semi-professional personnel, the medical equipment, laboratory equipment, the therapeutic programs and the administrative procedures, as well as the health measures for patients and employees. Prior to the granting of the annual license, the institutions must pass an inspection and comply with the recommendation of the State Fire Marshal or the City Fire Marshal in the City of Chicago. In addition, they must be approved by the Illinois Department of Public Health or the Chicago Health Department which inspects the water supply, the sewage disposal, pasteurization of milk, plumbing and food handling.

There are twenty-eight approved and licensed private mental facilities in Illinois, consisting of thirteen sanitaria, ten rest homes and five approved and licensed psychiatric units in general hospitals providing a total of 1151 beds.

The type of care offered by these institutions varies. The rest homes are mainly for the less disturbed patients, the patients who are chronically ill and the elderly or senile patients. Many of the sanitaria have excellent equipment and staff, and offer all forms of psychiatric therapy, electro-therapy and insulin therapy, hydrotherapy, physiotherapy, occupational and recreational therapy. The rates for treatment in these institutions vary, depending on the type of care required. Many have a standard rate for weekly care, with additional charges for special therapies.

There are five general hospitals which have established in-patient psychiatric units which have been approved and licensed by the Department. The total number of beds in these five units is 131. A new psychiatric unit has been added to the Michael Reese Hospital in Chicago,

and when licensed will add an additional 82 psychiatric hospital beds. More and more psychiatric beds are being added to the general hospitals throughout the country. This is a medical problem and general hospitals should be equipped to care for and to treat mental patients. This is a challenging problem and must be met by private general hospitals if we are to continue to make any headway against mental illnesses.

The following are the approved and licensed private mental facilities in the State of Illinois:

13 Sanitaria Providing 744 Psychiatric Beds

Bellevue Place	Batavia
Costeff Sanitarium	Peoria
Elm Lawn Sanitarium	Rockford
Fairview Sanitarium	Chicago
Hinsdale Sanitarium	Hinsdale
Lincolnview, Inc.	Springfield
Mercyville Sanitarium	Aurora
Michell Foundation	Peoria
The Norbury Sanitarium	Jacksonville
North Shore Health Resort	Winnetka
Parkway Sanitarium	Chicago
Pinel Sanitarium	Chicago
Resthaven Sanitarium	Elgin

10 Rest Homes Providing 276 Mental Beds

Arlington Heights Rest Home	Arlington Heights
Bellevue Place at Wooster Lake	Round Lake
Chateau Rest Home	Northbrook
Magnus Farm	Arlington Heights
Magnus House	Libertyville
Mather Home for the Aged	Alton
Rest Home for the Infirm	Elgin
St. Basil's Rest Home	Lake Villa
Shoreview Manor	Chicago
Weirick's Sanitarium	Elgin

5 Psychiatric Units in General Hospitals Providing 131 Psychiatric Beds

Loretto Hospital	Chicago
Mercy Hospital	Chicago
Michael Reese Hospital	Chicago
St. Luke's Hospital	Chicago
Wesley Memorial Hospital	Chicago

G. A. Wiltrakis, M.D.
Deputy Director

ILLINOIS ASSOCIATION OF BLOOD BANKS

Various physicians interested in blood banking, together with representatives of the larger blood banks in the State of Illinois met May 23, to organize a new society, the Illinois Association of Blood Banks. This society is organized as a non-profit organization for the following purposes:

1. Promote and foster the exchange of ideas and materials and the dissemination of information relating to blood banking and its technical methodology by education, publicity, and research.
2. Plan for and foster cooperation in times of disaster.
3. Function as a clearing house on questions relating to training of personnel common to such institutions.
4. Keep currently aware of and encourage high standards of service.
5. Foster, promote, aid, and encourage extension of similar services throughout the state.

It will be seen from a review of the purposes of this Society that its activities will be of great value to the people of the State of Illinois. The preamble states: "In order that we may render useful and adequate service to our communities, our hospitals, and those persons throughout the State of Illinois who need or will need whole blood or its derivatives, we have formed this association and adopted this constitution for the uses and purposes herein set forth." It is hoped in the course of time to establish the highest standards for blood banking within the State of Illinois and to make available, as broadly as possible, the blood and plasma, which are such life-saving measures. The outstanding record of these various blood banks within Illinois in providing hundreds of thousands of pints of blood and plasma to patients all over the State has been associated with the saving of many lives. The Association will endeavor to improve on an already splendid record.

ORIGINAL ARTICLES



Observations on Nethaphyl in Bronchial Asthma

I. Fond, M.D.
Chicago

Searching for a preparation that would give prompt and prolonged relief from an attack of bronchial asthma, with the least stimulating effect on the central nervous system, I have administered Nethaphyl† to a number of patients.

Nethaphyl was chosen because this combination appeared promising. Each capsule contains Nethamine Hydrochloride 3/4 gr., Butaphyllamine 2 gr. and Phenobarbital 1/4 gr.

The patients selected for this study were veterans under treatment for bronchial asthma at the Allergy Clinic of Veterans Administration in Chicago. The age range was 22 to 65 years. Fifty-seven were males, and three females. In fifty cases the asthma was uncomplicated. In four it was associated with pulmonary emphysema and in one with cor pulmonale.

The intensity of the asthmatic attacks was very severe in eight, severe in seventeen, moderate in thirty, slight in two. The duration of bronchial asthma varied from three to seven years, with the exception of two patients who had been affected for 27 and 28 years, respectively.

Previous to the experiment with the Nethaphyl the patients had been treated at the clinic for 4 months to three years. The basic treatment consisted of hyposensitization for their specific allergies, supplemented by ephedrine, Tedral or Hydryllin. During the present investigation, Nethaphyl was dispensed and alternated with Ephedrine and Amytal, without the patient's knowledge. The intermittent administration of Nethaphyl was continued in each patient for 3 to 6 months. Every patient was

†Nethaphyl, Nethamine and Butaphyllamine are registered trademarks of The Wm. S. Merrell Company. Amytal, Tedral and Hydryllin are trademarks, respectively, of Eli Lilly and Company, The Maltine Company and G. D. Searle and Company.

From the Dept, of Internal Medicine, Northwestern University Medical School.

Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are a result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

instructed to take one capsule of Nethaphyl only when needed for relief of an attack of asthma.

Of necessity, our findings are based on the verbal statements of the patients. All obtained relief beginning in 20 to 60 minutes and lasting from 3 to 12 hours. Side reactions were complained of by ten patients. (Table 1).

TABLE 1

SIDE REACTIONS	*No. Patients*	*%*
Tachycardia	9	15
Palpitation	5	8
Mild Nervous Excitement	10	16.6
Insomnia	9	15
Nausea and Vomiting	8	13.3

All of these side reactions were transitory and were evidenced only during the first few days of medication. In no case was it necessary to discontinue administration of the preparation.

One patient complained of profuse sweating and cramps and the drug had to be temporarily discontinued. However, a week later he was able to resume taking the drug without any untoward effect.

One patient complained of slight transitory headache.

All but four patients were anxious to continue to take Nethaphyl, because of the prolonged relief they obtained within a shorter period of time, without the accompanying tremor and nervousness which they experienced when taking ephedrine or Tedral, and without the drowsiness that they complained of when taking Hydryllin. One patient expressed preference for ephedrine and one liked Tedral best of all.

Most of the patients stated that if they took a capsule of Nethaphyl as soon as symptoms began to appear, in most instances it abated the attack of asthma. However, it had no effect once a severe attack of asthma developed. After being used for some time the dose had to be increased to two capsules taken at once.

Complete blood counts and urinalyses were made on each patient prior to the administration of Nethaphyl and at the conclusion of the period of observation. No particular changes were noted in the blood and urine.

COMMENT—Hensel[1], Simon[2] and Curry, Fuchs and Leard[3] reported the beneficial effects of preparations which give the asthmatic patient prompt and prolonged relief without the central nervous system stimulating effect of ephedrine.

Nethamine is related to ephedrine and can be described chemically as methylethylaminophenylpropanol—also known as 1-N Ethylephedrine. It was subjected to extensive pharmacological studies by Becker and co-workers.[4] Their acute and chronic toxicity studies in animals indicate that the compound is in the same order of toxicity as ephedrine. Experiments in dogs demonstrate that Nethamine is similar to ephedrine both quantitatively and qualitatively in its bronchial dilating action.

Experiments by the same workers[4] demonstrate, however, that clinically Nethamine should possess advantages over ephedrine for use as a bronchial dilator. It proved to be much less stimulating in animals than ephedrine as is indicated by the fact that the peak activity of rats was increased only approximately twofold following stomach tube administration of 50 mg./Kg. of Nethamine Hydrochloride; whereas, peak activity following the same dose of ephedrine hydrochloride was increased approximately fifteenfold. It was also found that the pressor activity of 1 mg./Kg. doses of Nethamine in pithed dogs was insignificant and approximately only one-tenth that of similar doses of ephedrine. The 1 mg./Kg. doses of Nethamine had no significant cardiac action.

It would be anticipated, on the basis of these findings in animals, that Nethamine should have comparatively few side effects in man.

Craddock[5] has shown that Nethamine was tolerated without any undesirable side actions in all but one of eleven patients who were sensitive to either ephedrine or adrenalin. Friedman and Cohen[6] found more numerous toxic effects from ephedrine than from Nethamine, especially in regard to the central nervous system.

Chemically, Butaphyllamine is theophylline aminoisobutanol. It contains approximately 67 per cent theophylline and is a stable water-soluble theophylline derivative. Smith and Jensen[7] demonstrated the stimulation of myocardial contractions produced by theophylline compounds in experimental heart failure and the rapid removal of the pulmonary edema and congestion resulting from the experimental heart failure.

Steinberg and Jensen[8] demonstrated that theophylline aminoisobutanol caused a fall in venous pressure and a shortening of circulation time.

These effects were more pronounced the more these functions were elevated above normal.

Young and Gilbert[9] demonstrated that theophylline ethylenediamine will lessen greatly the constricting action of histamine. In guinea pigs it abolishes severe respiratory symptoms and thus proves the pharmacologic basis for the use of theophylline preparations in the treatment of bronchial asthma.

Thompson and Warren[10] have shown that theophylline aminoisobutanol and theophylline ethylenediamine produced no evidence of toxicity in dogs following the administration of 20 mg. per kilogram, either intravenously or orally, and no toxic effects were observed in rats fed amounts of the drug up to 34 mg. per kilogram daily for as long as sixty days.

These studies indicate that Butaphyllamine (theophylline aminoisobutanol) has the basic action of other theophylline derivatives with the possible advantage of better toleration.

CONCLUSION

The present study shows that Nethaphyl is an effective, safe and well-tolerated agent in the treatment of bronchial asthma. It was used for a fairly long period of time and proved to be effective. However, after a while the dosage had to be increased. This confirms Simon's[2] statement to the same effect.

SUMMARY

1. Sixty cases of bronchial asthma received Nethaphyl for relief of their asthmatic attacks for a period of 3 to 6 months.
2. Ten patients complained of transitory mild side reactions.
3. Fifty-six patients preferred Nethaphyl because of prolonged relief without the central nervous system stimulating effect of ephedrine.

1134 W. Pratt Ave.

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ASTHMA AND GROWTH

Children with untreated asthma suffer growth disturbances, emotional difficulties and developmental abnormalities. Todd et al, in a study of 60 allergic children showed that 60 per cent had gross orthodontic deformities; and others have indicated that allergic children are likely to be small both as to height and weight for age. Cohen and Abram compared 150 allergic and 102 nonallergic children using the Wetzel Grid. They concluded that active allergy is a common cause of growth failure and that control of active allergy may be accompanied by a regain in growth provided that an adequate diet is available. Clein after observing 100 allergic children for ten years stated that with competent treatment of their allergic complaints, these children can grow and develop normally. *Excerpt: Asthma in Children, Avery L. Cotton, M.D., New Orleans M. and S. J., June*, 1951.

Errors in the Treatment of Common Fractures

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Chicago

The purpose of this paper is to outline the major errors we have observed in the treatment of common fractures. Some of them have been committed by all of us at one time or another. Others may be the fault of some of us in failing to impress upon our students basic principles to which we must all adhere.

Most of the errors encountered in the treatment of fractures of the extremities are errors of omission and most of them can be avoided.

If I was asked to name the most important single factor in the treatment of fractures, traction would be my answer. Failure to properly apply traction is, I believe, the most common error. The adequate use of traction before manual manipulation of a fracture will aid in reduction and prevent many complications. When continuous traction is necessary we have a choice of skin traction or skeletal traction. When using skin traction, we believe, that the limb should not be shaved. It is washed with soap and water followed by alcohol and ether. Plain adhesive tape should not be used as it frequently tears and excoriates the skin. Moleskin adhesive is advised. It is applied parallel to the limb and is not criss-crossed. It is best secured to the limb with elastic bandage. In elderly patients particularly, one must be extremly careful not to wrap the bandage too tightly since arteriosclerotic limbs may become gangrenous from constriction. Always apply the maximum amount of weight in the beginning, while the skin is in good condition, the adhesive qualities of the moleskin are the best and before the muscles have become set.

Skin traction is only efficient when used in the treatment of fractures of the femur or humerus. When fractures of the forearm or leg bones require traction it must be skeletal traction.

Secondly, one must remember, it is a fallacy to believe that because a fracture is well reduced and well immobilized that it can be forgotten until firm bony union has occured. The position may be lost as swelling and edema subside. This situation is best treated by immobilizing the freshly reduced fracture in a posterior plaster mold supplimented by an elastic bandage for seven to ten days at which time a circular plaster cast may be applied safely. If a circular plaster cast is applied after reduction it should be changed also at the end of seven to ten days. Check x-rays should be taken before the cast or mold is changed as the fragments may have slipped already. Also the extremity should be x-rayed again after the application of the new cast.

When a bone is broken the object of treatment is to obtain union of the fragments in a good functional position with restoration of motion in the joints and power in the muscles of the limb in the shortest possible time. Union is usually most rapidly and surely obtained if the broken ends of the bones are in contact and immobilized until firmly united by callus.

Quoting Sir Reginald Watson-Jones, non-union of fractures is due to the failure of surgeons much more than to failure of osteoblasts. The principle cause of non-union of closed fractures without interposition of soft tissue is inadequate immobilization. Impairment of blood supply may delay the process of repair but if fractures showing this delay are protected long enough they will unite. Distraction causes a marked delay in the healing of fractures but union will still take place if immobilization is prolonged. Even severe infection of a fracture is not a cause of non-union if immobilization is maintained.

What constitutes adequate immobilization?

One must remember that adequate immobilization does not necessarily mean absolute immobilization since immobilization may be secured by recumbency, by bandges or slings, by traction, by splints and by plaster of paris casts. The character of immobilization depends, a good deal,

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upon the type of fracture, the tendency to displacement of the fragments by muscle pull or gravity and also upon the choice of the surgeon. In fractures of the spine or pelvis, for instance, without displacement, simply placing the patient recumbent on a Bradford frame will often afford adequate immobilization. In fractures of the clavicle or lower end of the humerus sufficient immobilization may be obtained by bandages and adhesive tape. The same is true in certain fractures about the ankle without displacement. In fractures with a tendency to displacement, immobilization must be obtained by traction or splints. When traction is used, especially in the femur and bones of the leg splints are necessary to support the leg and prevent posterior angulation.

We prefer plaster of paris to the average splint with the exception of the Thomas splint for the lower extremity. It is our experience that most fractures can be adequately treated by plaster of paris casts, that the patients are more comfortable in casts than in splints and that casts require less attention after they are applied.

Early reduction and adequate immobilization are essential. The old belief to wait for swelling to subside before manipulation is attempted is to be condemned. The sooner a fracture is manipulated, after its occurrence, the better the chance of obtaining good reduction. Hippocrates, the father of surgery, cautioned that "extention of fractured or dislocated bones is not to be delayed to the third day but is to be carriel out on the first day". Immediate handling of the limb is important. A fracture which can be reduced easily by simple methods within an hour of its occurrence may become a very difficult problem twenty-four hours later.

Fractures about the wrist are probably the most frequently encountered and frequently poorly managed. In particular the Colle's fracture, which involves the distal one inch of the radius, produces shortening of the radius and posterior angulation of the articular facet. The criterion of good reduction includes restoration of the normal length of the radius, one half to three quarters inch longer than the styloid process of the ulna, and the articular facet facing forward and downward. If properly reduced this fracture has little tendency to displacement. Immobilization should be continued for five to six weeks. The cast should not extend beyond the mid-palmar crease and we suggest that the sling be discarded after twenty-four to forty-eight hours so that fingers, elbow and shoulder may be put through a normal range of motion.

Injuries at the wrist are not always as simple as they seem. The proximal carpal row should always be investigated as these bones too may be involved. Fractures of the scaphoid and dislocations of the lunate may be overlooked and produce considerable disability when untreated.

We have noted that the most common error in treating any of the fractures about the ankle to be too early weight bearing. With good reduction obtained one may be fooled, with an x-ray through a cast, into believing the fracture is firmly united, discontinue immobilization and permit weight bearing. Disastrous results ensue, the soft callus gives and a permanent deformity results.

There are few fractures in which complete correction of the deformity is more important than a fracture about the ankle for if the body weight does not pass through the middle of the astragalus there is danger of disability. For normal function the astragalus must remain in a fixed position secured by the malleoli.

If reduction of a fracture about the ankle cannot be obtained or if it can be reduced but not maintained early open reduction and internal fixation is advised.

Failure to note and record the blood and nerve supply distal to a fracture is an error too commonly encountered. Damage to either or both at the time of fracture is of utmost importance from a prognostic point of view and in the choice of the method by which the injury is to be managed. Also it may be a cause for great concern and embarassment after institution of treatment to learn for the first time that there is loss of nerve or blood supply to the extremity.

In conclusion then the most common errors encountered are:

1) Inadequate immobilization
2) Failure to properly apply traction
3) Too early weight bearing in fractures of the ankle
4) Failure to note and record blood and nerve supply to an injured extremity.

HOUSE OF DELEGATES



FIRST SESSION, MAY 22, 1951

The first meeting of the House of Delegates of the Illinois State Medical Society was held in the Hotel Sherman, Chicago, on Tuesday, May 22, 1951.

The meeting was called to order at 3:20 P.M. by the President, Dr. Harry M. Hedge, Chicago.

THE PRESIDENT: The Secretary has an announcement to make at this time.

THE SECRETARY: We have a gentleman here this afternoon representing this Hotel whom I would like to present to you. I think he has an expression of greetings he wants to give you. Mr. Earl Benedict, Convention Manager of the Hotel Sherman.

MR. BENEDICT: We are indeed very glad you are here, and that we truly mean. We are only sorry that we had not fully completed the improvements we are making in the Hotel. In this last twelve months we have tried to make this hotel over and there is still work to be done. We have for the last several months been working with Dr. Mason and Dr. Camp, and we tried to obtain a picture of what you needed and we are still here to help you.

Now, Mr. President, on behalf of the Hotel Sherman it is my privilege to present to you this gavel. I sincerely trust you will not have to use it on the fine bunch of doctors. I thank you.

THE PRESIDENT: That is a real surprise. From the time we started our work at this hotel, Mr. Benedict always had his office open and his telephone open and had anticipated our desires even before they were expressed. We are certainly grateful to him for his cooperation and also grateful to the hotel for housing us this year.

The first order of business was the roll call of the officers and members of the Council.

THE SECRETARY: We are very sorry to report that Dr. Wade Harker, Councilor of the Third District, is ill at home and unable to be here.

The next order of business was the report of the Credentials Committee.

DR. HARLAN ENGLISH, Danville: There are seated 142 delegates, 16 members of the Council and 5 officers, making a total of 163. I move you that the 163 constitute the voting strength of this House of Delegates. (Motion seconded by Dr. Charles H. Phifer, Chicago, and carried).

THE SECRETARY: Evidence is presented to support the report of 142 delegates, 16 members of the Council and 5 officers, constituting the voting strength of the House.

THE PRESIDENT: The next order of business is the roll call by the Secretary.

DR. CHARLES H. PHIFER, Chicago: I move that the signed attendance slips constitute the official roll call for this meeting. (Motion seconded by Dr. Fred Muller, Chicago, and carried).

THE PRESIDENT: The next order of business is the approval of the minutes of 1950 meetings of the House as published in the July and August issues of the Illinois Medical Journal.

DR. W. E. KITTLER, Rochelle: This seems to be my privilege each year. I move that the minutes be approved as published in the July and August issues of the Illinois Medical Journal. (Motion seconded by Dr. Elmer V. McCarthy, Chicago, and carried).

THE PRESIDENT: The next order of business is the presentation of Outstanding General Practitioner Award to E. E. Davis, Avon. Each year we select one of the members of the Illinois State Medical Society to whom we award a certificate as the outstanding general practitioner of Illinois for the year. Out of some fourteen or fifteen names that were considered, and they were considered very seriously for a considerable period of time by those who were doing the selecting, you, Dr. Davis, were selected as the out-

standing practitioner of the State of Illinois for 1950. It is my privilege and my honor to present to you this certificate which I hope you will hang in a conspicuous place where those associated with you and come to you will recognize that you are to us and to the other people in the state of Illinois an outstanding general practitioner.

DR. E. E. DAVIS: Mr. President, Members of the House of Delegates and Guests: I am indeed grateful beyond all power of expression for this honor that has been designated to me. I appreciate it and appreciate the honor of representing the general practitioners of this state of Illinois. I think it is greater than I deserve.

When I began the practice of medicine the proportion of men doing general work was far greater than it is today. Many men of that day knew little or nothing about the scientific practice of medicine. I counseled with men who had never been to medical school, but obtained their license to practice from years of experience under a preceptor.

The men of that time rendered a worthwhile service. They went when they were called, did the best they could and made the patient and family feel better. It was the spirit with which this devoted service was rendered that endeared the medical profession to the people generally and created the doctor-patient relationship of which we have been so long proud. Now contrast this with the attitude depicted in the following story:

A lady fainted on the sidewalk of a busy street. She was picked up by strangers and carried directly to a doctor's office. How they got by the receptionist is not known. The doctor emphatically told them all that his practice was all referred work and that his practice was entirely limited to the nose. At that time the patient roused up and inquired, "which nostril doctor?".

Now as medical education advanced, more tests were available and more operations could be done to cure the patient. The cost of adequate medical care rose beyond the average patient's ability to pay. This constitutes a real and genuine problem. I am wondering if a part of this problem was not produced by us physicians ourselves. First, by not charging fees commensurate with the services rendered, and the ability of the patient to pay. Second, by ordering tests that were not really necessary. For instance, I sent a patient to a hospital with a positive diagnosis of acute duodenal perforating ulcer. He was seen at noon by a surgeon who ordered an x-ray picture, complete blood count, typing, etc., urinalysis, and what have you. He was successfully operated on at 8 P.M. and the diagnosis confirmed at the operation. He was treated most scientifically and I have nothing but praise for scientific medicine and I would not in any way depreciate it in the least. But was all this laboratory work necessary when the diagnosis was plain and easy? Why subject this patient to eight hours of hell when the patient had been advised that every hour's delay in getting the operation done lessened his chances of recovery?

Last year Andy Hall recited a rhyme describing an old-fashioned heaven and hell. I have mentioned a modern hell and a modern heaven would be the practice of real scientific medicine guided by the golden rule.

When a man has lived in a small town a long time he frequently gets a pet theory as to what is wrong with the world and what should be done to correct it. I have such an idea regarding our educational system. I think it is majoring in athletics when it should have been majoring in good citizenship. A small community will pay $100 to get a speaker for an athletic banquet, and $20 for one at the graduating exercises.

Good citizenship should be so emphasized in this country that a politician elected to office should be graduated from the status of politician to that of a real statesman. In fact, I think religious education has lagged so far behind scientific education that it is a crime. We don't farm and we do not practice medicine like we did fifty or a hundred years ago. Still we don't know any more about the application of the golden rule than we did then.

The Sermon on the Mount is a way of life but its application to today's problems has never had any scientific study. There are some problems in right living that the medical profession might do well to study scientifically. I wonder if many of the frustrations and tensions that the psychiatrist talks so much about, could not be prevented by such a study. In Alcoholics Anonymous one alcoholic saves himself by his effort to save others. The medical profession might well ponder the example.

THE PRESIDENT: Thank you, Dr. Davis, it is a pleasure to have you around.

The next order of business is the appointment of Reference Committees by the President. The following Committees have been appointed. As their names are called, the members of committees will remain standing until the Chairman receives his portfolio. He will then tell the members when and where the Committee will meet.

(a) *Committee on Attendance:* Charles Pope, Chicago, Chairman, John Scully, Chicago, H. W. Sandeen, Woodstock, and A. R. Whitefort, St. Elmo.

(b) *Committee on Reports of Officers:* To receive and report on reports of President, President-Elect, and Secretary-Treasurer: W. A. Monaghan, Taylorville, Chairman, R. C. Oldfield, Oak Park, A. J. Linowiecki, Chicago, and R. M. Watrous, North Chicago.

(c) *Committee on Reports of Councilors:* To receive and report on reports of Chairman of the Council, reports of the eleven Councilor Districts, and Councilors-at-large: Warren W. Furey, Chicago, Chairman, E. T. McEnery, Chicago, F. J. Stewart, Kewanee, and E. P. Burt, Peoria.

(d) *Committee on Reports of Standing Committees:* To receive and report on reports of Committee on Medical Service and Public Relations, Medico-Legal Committee, Committee on Archives, Committee on Medical Education and Hospitals, Committee on Medical Benevolence, Committee on Medical Testimony, and Grievance Committee: David B. Freeman, Moline,

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Chairman, T. G. Knappenberger, Champaign, Frank Maple, Chicago, Richard Greening, Chicago.

(e) *Committee "A" on Reports of Council Committees:* To receive and report on reports of Educational Committees: To receive and report on reports of Educational Committee, Scientific Service Committee, Postgraduate Education Committee, Fifty Year Club Committee, Medical Economics Committee, and Committee on Physical Therapy: G. Henry Mundt, Chicago, Chairman, Robert Mustell, Chicago, D. H. Trumpe, Springfield, and V. V. Rockey, Freeport.

(f) *Committee "B" on Reports of Council Committees:* To receive and report on reports of Advisory Committee, Illinois Public Aid Commission, Constitution and By-Laws Committee, Advisory Committee, United Mine Workers, Committee on Voluntary Prepayment Plans ,and Committee on Mental Hygiene: James H. Hutton, Chicago, Chairman, R. F. Millet, Macomb, M. M. Hoeltgen, Chicago, and E. F. Neckerman, Elmhurst.

(g) *Committee "C" on Reports of Council Committees:* To receive and report on reports of Committee on Cancer Control, Advisory Committee on Fetus and Newborn, Committee on Tuberculosis Control, Committee on Venereal Disease Control, Advisory Committee to Veteran's Administration, and Committee on Military Affairs and Emergency Medical Service: Bernard Klein, Joliet, Chairman, J. H. Maloney, Rockford, Karl Vehe, Chicago and John R. Wolff, Chicago.

(h) *Committee "D" on Reports of Council Committees:* To receive and report on reports of Committee on Rural Medical Service, Crippled Children's Clinic Committee, Committee on Industrial Health, Maternal Welfare Committee, Ethical Relations Committee and Committee on Nursing: A. F. Goodyear, Decatur, Chairman, Frank E. Bihss, East St. Louis, Joseph Sodaro, Forest Park, and B. K. Lazarski, Chicago.

(i) *Committee on Resolutions* and to receive and report on reports of: Report of the Editors of the Illinois Medical Journal, Report of Editorial Board and Journal Committee, Committee on Scientific Work, President of the Woman's Auxiliary, Advisory Committee to the Woman's Auxiliary, and to receive resolutions as referred by the President: S. M. Goldberger, Chicago, Chairman, J. C. Redington, Galesburg, Charles Allison, Kankakee, and Patrick McNulty, Chicago.

(j) *Committee on Miscellaneous Business:* To receive and report on reports of Committee on Nutrition, Committee on Medical History, Delegates to the A.M.A., Committee to Investigate the Private Practice of Full-time Employees, Interprofessional Relations Committee, and any other matters referred by the President: George L. Drennan, Jacksonville, Chairman, Frank Deneen, Bloomington, Carl Steinhoff, Chicago, Frank Fowler, Chicago.

THE PRESIDENT: The next order of business is consideration of annual reports as published in the Handbook, with supplementary reports as desired.

ANNUAL REPORTS OF OFFICERS & COMMITTEES

REPORT OF THE PRESIDENT

This convening of the House of Delegates of the Illinois State Medical Society marks the time for me as the retiring one hundred and eleventh President to bring my report to you. This has been a year of activity in many ways, a year of great stress nationally and on the state level; a year in which we have seen many changes, each of which has brought with it the elation of success or the sting of defeat.

The medical profession as a whole has made real progress scientifically and fraternally. It has learned the meaning of unity and what results may be attained when this unified action has been employed.

During this period the national conscience has been awakened and in some instances directed to more straightforward and honest thinking. Some of our national leaders, however, have changed their attitude from that of following complacently an assumed mandate to one of bitter sarcasm and vindictiveness due to the change in reflected opinion from the grass roots of the nation.

The results of the work at the last election were enlightening. The medical profession had stood firm, demanding in every pledge and promise that our policy of free enterprise be preserved. The results were an indication that the influence of the doctor was still to be a major element in reckoning when fundamental problems were at stake. It was most gratifying to see that when the movement was once initiated by the physicians asd presented to the public through their channels, a warm response came from that public at large and also as quickly and willingly from the associated professions. The unity if the healing arts personnel and the willing cooperation of the allied groups made historic record of the respect in which the physician today is still held.

Let me then at the beginning of my report make a few recommendations which might be lost if added to the conclusion for some may fail to read to the end: (1) Let the physicians continue their civic mindedness and willingly serve on local School Boards, Boards of Health, as public officers, be active in church and civic organizations and give their culture and education to these activities. (2) Let us continue the medical tradition of scientific honesty. Let us look to facts and not fancies. Let us evaluate our findings both social, economic and political, by those things which we can positively weigh rather than those which may be attended with glory and flattery. Let us keep an open mind. (3) Let us discourage the publicity of products which have not yet passed the rigid test of the laboratory and the clinic and refuse to lend our names to questionable unproved products. (4) Let us continue to discourage the publication of unproven scientific material in the lay press or using such media for the monetary furtherance of personal

ambition. (5) Let us increase our influence to curtail the advertising and blatant circus-like statements made concerning patent medicine products with all-healing qualities over the radio and the television, by which these false promises are forced into the sanctuaries of the home and family circle. (6) Let us so cooperate with the public and let them know we are so in sympathy with their problems that when scientific advice regarding medical questions and health activities are sought we may be the source of such seeking and not encourage the seeking from such branches of our political family as Labor, Social Security, etc. They have great service to render in their own field and can much better serve there than by attempting to furnish information and establish rules and policies for preservation of the health of the nation. (7) Let us encourage much more cooperation between the members of the healing arts, such as physicians, dentists, pharmacists, veterinarians, nurses, hospital administrators, osteopaths, optometrists, etc. We must all work in harmony for the furtherance of free enterprise and the retention of the American way of life.

THE COUNCIL. It has been a pleasure to work with the Council. They have been most cooperative and serious. So many instances come to mind which would have been a real education for any doctor to sit in session and see the unselfish work that is accomplished by these men from all over the state, who give up their days of personal gain to travel at night in order to arrive at the place appointed for the Council meetings. Dr. Charles P. Blair as the efficient Chairman of the Council has conducted business with dispatch and courtesy, interpolating an occasional bit of humor to lessen the strain and tension of the moment. The deliberations of this body require many hours at each session during which the presenting problems are discussed in detail and a harmonious solution usually results.

THE SECRETARY-TREASURER. The continuity of the business of the Society is well preserved in the person of our Secretary-Treasurer, Dr. Harold M. Camp of Monmouth. By his long service he is thoroughly conversant with present and past policies and with his wide acquaintance over the country gives great support to the Chairman of the Council and other officers of the Society. His promptness in correspondence and payment of vouchers keeps the credit of the Society at an enviable high level. Many times he is compelled to catch early trains or drive through inclement weather to make appointments in order that the work of the Society may remain at its usual high level of performance, and through it all he maintains his cheerful mien and unruffled composure. This report would not be complete without mention of Mrs. Frances Zimmer who gives valuable assistance to the Council by recording their activities.

EDITORIAL BOARD AND JOURNAL COMMITTEE.—The Editorial Board under the leadership of Dr. James H. Hutton and his group of advisors has rendered an especially high grade of service to medicine this year. The assignment of papers to men competent to judge of their merit and the evaluation of their reports has been the means of making the Illinois Medical Journal one of the outstanding periodicals in its class in the country. The meetings of the Editorial Board and the Journal Committee are usually held together so that questions which are covered by both groups may be discussed with all members present. Dr. Harold Camp has had the assistance of Dr. Theodore Van Dellen as Associate Editor, thus giving some relief in the detail work of the office. Mr. Ed Malley as Business Manager is ever alert to the best changes that can be effected to make the appearance and the readability of the Journal at its best. Some of the changes made give a clearer cut first impression for the printed page and thus make it more attractive to one wishing to peruse its contents.

THE PUBLIC RELATIONS COMMITTEE.—Time and space will not permit the recounting of even a part of the activities of the Public Relations Committee. Under the direction of Dr. Percy Hopkins and with the able advice and assistance of Mr. Jim Leary and Mr. Jack Neal the ramifications of the work of this committee have been advancing ever forward. A new policy was established this year of district meetings and closer relationship with the outside agencies to bring medicine to the public and let its worth be known. When such an all-including program is undertaken, mistaken values are sometimes brought to the front which, when corrected, mean much to our progress both culturally and scientifically. Our relations with the press, especially the metropolitan press, have been very helpful: Mr. Roy Gibbons of the Chicago Tribune, Mr. Arthur J. Snider of the Chicago Daily News and Mr. Hugh S. Stewart of the Chicago Herald-American have gone beyond their required positions to cooperate with us. They have stood on the firm ground of opposing the Socialist State and Socialized Medicine and have in every way championed our cause as against the rubber stamp in high office. We give them and others who have so aided us in our work of the year our thanks and our salute.

THE EDUCATIONAL COMMITTEE.—Among the most active supports which has kept medicine in the forefront of public thought this year has been the Educational committee. Dr. Charles P. Blair as its guiding officer and his able committee have ever been on the alert to utilize to the best advantage every avenue for education of the physician and the public at large. Miss Ann Fox has spent many weary hours both at the office and at home after closing hours to perfect the scripts for the radio addresses and the television programs to be presented. In the detail of this work she had also the untiring help of Mrs. Kathryn Simmons and Miss Josephine Linder in the office.

During the last year the Educational Committee drew a number of signal honors. "Health Talk" was awarded the gold statuette for its efforts over the

WGN-TV by a popularity pole of over 41,000 votes of the subscribers to Television Forecast Magazine. Presentation was made by the magazine over television and was received in the name of the Society by your President. Then again in the annual contest conducted by the Illinois Women's Press Association, "Health Talk" was awarded first place for the second consecutive year, while in the contest sponsored by the National Federation of Press Women the same publication has been submitted for competitive judging. When the cast was taken to Columbus for television, the Illinois Committee won recognition when the publicity issued for this telecast and television scripts placed first in their division in the writing contest sponsored by the Illinois Woman's Press Association. We feel very proud of these achievements. It would certainly be unfair if we failed to mention the untiring effort in all our work in this field given by Dr. Van Dellen who has appeared on every television program and by his apt inclusions of ad-libing remarks has helped the smooth production of the presentations.

RELATIONS WITH LABOR. During the year we have continued to have our contacts with labor in its various fields. We have learned to our pleasure that the leaders in this field are gentlemen who, like ourselves, are seeking but one end and that is the better care for those whom they represent. The difficulty of bridging the gap of what was said to be between the "high brow, egotistical, stiff shirts" (the doctors and "the low-brow political, brow beating champions of the Masses" (the labor leader) seems now to have been accomplished and a much better understanding exists between the two groups. Let me quote from a personal letter sent as a Christmas greeting from a representative of labor to your president: "The end of December will complete six months of operation for the revised medical program of the Welfare Fund . . . Throughout the past year the medical profession has again demonstrated its willingness to cooperate with the medical program of the Welfare Fund. You have been most helpful in assisting the Welfare Fund to achieve its goal of providing the miner and his family with the medical and hospital care that has been authorized under the present program." We need and crave harmony and a feeling of fellowship in all our daily relationships in order that our lives may be filled with a genuine security, that of faith in our fellowmen. Much of the success of this program has been due to the untiring energy and effort of Dr. Everett Coleman of Canton.

COMMITTEE ON BENEVOLENCE. Our Benevolence Fund has now come into its own. Instead of a few hundred dollars that might be used to help the less fortunate of the medical practitioners or their families, it has now become a fund of sizeable proportions. I feel it is not wise to indefinitely keep the fund increasing in amount, but when we remember the value of its ministrations, we must be ready again to vote from our income or our funds as time and needs may dictate that this fund may be ever commensurate with the need in order that we may help in a substantial way those who are of our fraternity and have given of their life and means to help humanity. Let us think well as we consider this problem at this meeting of the House of Delegates.

RURAL MEDICAL CARE. Dr. Harlan English in his usual thorough manner has made this work a real credit to all of us. His relation to the University of Illinois and by his contact with Dr. Andrew Ivy has done more for the distressed areas of Illinois in arranging for medical care than the Federal Security Administration has been able to do even with threat of force in the past ten years. The understanding aid given by the Illinois Agricultural Association in this field has made it possible to have at the present time twenty-seven men in preparation to go back to these areas of the State of Illinois and without duress give medical care equivalent to that obtainable even in our metropolitan areas. The boys who have applied for aid in entering school and for financial aid in pursuing their medical education have been of the highest caliber and have established their worth to medicine and to the State. These men are aided to the extent of $1,000 per year for five years that they may enter and pursue their medical studies with the understanding that they return to their local areas to practice for a period until they are able to return to the fund that which has been given them for aid in the period of study. This last year, in view of the fact that the cost of everything has advanced, it has been arranged to loan each of them $1,250 per year for four years and let them depend on their income as interns to help their finances in that last year of preparation.

NATIONAL, STATE AND LOCAL DEFENSE. No little part has been played by the medical men in making preparation for a possible national attack of atomic bombs or all-out war. The time has not been measured in hours but in days that has been expended without compensation by such able individuals as Dr. Earl Blair, Dr. Herbolsheimer, Dr. Roland Cross and Dr. Herman Bundesen. Many others have also given of their time and experience to formulate a workable plan to be used in case of such a catastrophe.

THE WOMAN'S AUXILIARY. A group of enthusiasts who plan their work and get things done is the Auxiliary to the Medical Society. Their new bulletin "What's My Name" was published in January, filled to the last paragraph with instructive and interesting material. The work that they have done and are doing each year needs only to be known to be appreciated, and we congratulate Mrs. Effie S. Sibilsky and her associates in their appreciated efforts.

THE GRIEVANCE COMMITTEE. A new committee established this year is the Grievance Committee which acts as a sort of Supreme Court to pass on the rulings and findings of the local committees but without authority to institute any action not already begun by the local society. Such a committee is a step in the right direction that the first interest of the medical profession is good medicine and the best care of the

sick of the state and the nation. The basis of all medical ethics is whether the patient has had the best possible care and that the proper precautions have been recognized medically and surgically. Conference, cooperation, consultation and consideration all enter into the care of every case presented to the medical practitioner for his benefit and for the aid of the patient in question.

FINANCE COMMITTEE. This is a prosaic title but when the workings of the committee are understood it springs into life and is full of virile considerations. Responsible for the spending of thousands of dollars a year, it assumes its responsibilities philosophically. There are needs for education, promulgation of new information, protection of the rights of the practitioner and many other calls which need financing and they all come to this committee. The Council is the final authority for the expenditure of funds but this last year it delegated to the Finance Committee the authority to investigate all major expenditures before being passed upon by the Council. When approved by the Finance Committee and approved by the Council, such necessary expenditures may then be made. Dr. Edwin Hamilton as Chairman takes time from his busy life in official medicine to call, meet and discuss all these problems as they arise.

THE ADVISORY COMMITTEE TO THE ILLINOIS PUBLIC AID COMMISSION. During the past year this Advisory Committee celebrated its tenth year of service. A special dinner was given to celebrate the event. A plaque was inscribed and presented to the Chairman, Dr. Everett Coleman, in appreciation of the work done. The praise of the committee past and present was included and the names of its members included in the citation. Also a special edition of the Illinois Public Aid Bulletin was issued which included the record of the work done and the picture of those contributing their time.

I wish it were possible to mention every worker in the state who has contributed to the welfare of the Society in the past year. For me it has been a very happy year with no single incident of cross purpose and no opposition without or within the ranks to mar its tranquility. It has been a great honor to be one chosen to follow in the steps of such a distinguished list as has preceded me in the last one hundred years of medical service. All I can say at this time is from the depth of my heart I thank you all.

Respectfully submitted, HARRY MALCOME HEDGE, M.D., *President, Illinois State Medical Society.*

REPORT OF THE PRESIDENT-ELECT

During the past year, I have found that the office of President-Elect of the Illinois State Medical Society is very largely a training post, which prepares one for the year that is to follow. I have attended all the meetings of the Council during the current year, which has served to make me even more aware of the problems of medicine and the medical profession. I have become better acquainted with the officers and men of the Council, who are your executives and advisors, and I have especially noted the sincere service and good judgment, which was so evident in the work of Dr. Harry M. Hedge during his year as our president. It has, indeed, set a very high standard for the coming year. And, Dr. Charles P. Blair, as Chairman of the Council, including the chairmen of the outstanding committees, have shown remarkable understanding in meeting current problems and planning a sound future. I can assure you that in their selection you made no mistake.

It has been my privilege to speak to a number of lay groups on citizenship responsibility, emphasizing the socialistic political trends in our national administration. It was also my privilege to represent Dr. Hedge at a Parent-Teachers' Association general meeting in Quincy, an oranization meeting of the Champaign-Urbana Women's Auxiliary, and the Annual meeting of the Practical Nurses' State Association in Moline.

Through the contacts and experiences of the past year, I have discovered that the medical profession is *now* a very powerful force in arousing favorable public opinion. It is my belief that an aroused electorate is the only means for securing political support so necessary in our campaign against socialism. Therefore, let us, in order to consolidate and coordinate our resources on our fighting front, adopt as our slogan for the coming year, "Medical Men—Their Citizenship Responsibility."

Respectively submitted, C. PAUL WHITE, M. D., *President-Elect, Illinois State Medical Society.*

REPORT OF THE SECRETARY-TREASURER

Conditions have changed materially since the last Annual Meeting of this Society. Last June, as you all know, the North Korean Red army crossed the 38th parallel, and trouble began. Whether or not our immediate response was merely "police duty," we are at war. Many Illinois physicians in the first two established priorities have left their work, and are now in the Armed Forces.

The office of the Secretary has had many requests for replacements in those instances where the only physician has been called to service. Likewise, we have had the usual number of communities wanting a physician, and asking us to find one for them quickly. Some of these communities have not had a resident physician over some period of years. As usual, we have investigated all of these requests rather critically and to good advantage.

We send out forms to the respective communities to get factual data, and to enable us to determine the urgency of the request. Occasionally the request comes from someone in the community who has something to sell or to rent. We also receive requests to find an additional physician for a small town already having a doctor who is physically and professionally qualified to care for the local needs. Our investigations occasionally elicit the information that the request comes from a citizen who has a personal grudge, and is determined to get even with the local physician.

We receive many letters from physicians who recently have completed their internship or residency, and desire a location. Realizing that in a number of instances

during the past year physicians have located in a town for a few months, then finding themselves in priority one, have been called to service, we try to determine both the local Selective Service Board Classification and the priority rating of the inquiring physicians before giving information concerning Illinois locations.

Likewise, we inquire concerning the physician, his training, experience and family. Some who contact us have already practised for as long as fifty years in the city, and suddenly desire to become rural physicians. Most of these elderly physicians cannot undergo the rigors of rural practice where they must be on duty 24 hours each day, make night calls, care for obstetrical cases, etc., so their applications for a new location are looked over rather critically.

THE F. B. I. INVESTIGATION—During the summer of 1950, a representative from the Federal Bureau of Investigation called at the Monmouth office, and informed us that the Department of Justice of the United States Government had ordered the F. B. I. to make a careful investigation of the records of the Illinois State Medical Society to see if there were violations of the Sherman Anti-Trust Act, in our activities. We informed them that the Secretary was the custodian of the records of the Society, and we would require approval of the Council before we could make these records available.

The matter was brought before the Council at its next meeting, and permission was given the Secretary to make these records available as requested. The Council was unanimous in the opinion that the Society had nothing to hide, and that the investigation would not elicit evidence of any Sherman Act violations.

On September 13, 1950, the F. B. I. agents came to Monmouth, and inspected the records in our office. Nothing was taken away at any time, except the Illinois Medical Journals. The General Counsel of the Society, Mr. John W. Neal, was present when the investigation was started, and on several days while the investigation was under way. The four men assigned to the case worked in the office during a four week period, and showed that in addition to being gentlemen, they were efficient, paid strict attention to the matter in hand, and were desirous of completing the investigation as soon as possible.

For your information, our correspondance, in and out, dating back to 1938 was looked over; the complete file of the transactions of the Committee on Voluntary Prepayment Care Plans was photographed, and the men were instructed to look over the transactions of the House of Delegates back to 1938. To make this task easier for them, we gave them the complete files of the Illinois Medical Journal from 1938 to the time of the investigation, which they took from the office for subsequent examination. These, as you know, contained all actions of the House of Delegates for each year within the period for the investigation.

We have not heard anything relative to the investigation to date.

ADDITIONAL SERVICES IN SECRETARY'S OFFICE—The Secretary's office now has the files and mailing lists for the work of John W. Neal, which obviates the necessity for maintaining a separate office and personnel for a period of six months each biennium. The office has the equipment and personnel which can be used for these services at a considerable saving for the Society. This means more work for our office force, but so far the plan has worked out quite satisfactorily.

We now have a complete stencil roster of the entire membership of the Society which is maintained as nearly accurately as possible. With a membership of 10,000, there are changes of address and removals on account of death, or relocation reported each month. Unfortunately many of these changes are not reported promptly to our office, and we continue to send letters and other releases to the last reported address of the member. These stencils use home addresses only, and this leads to some of the errors in our files since the men do not report the change of home address as readily as change of office address.

THE ANNUAL MEETING—This is the first meeting of the State Medical Society in Chicago and outside the Palmer House in ten years. The meeting last year in Springfield brought another convention to the Palmer House for the same week, and this one is scheduled for the same date again this year. We were fortunate in being able to find another hotel with ample facilities. We believe the arrangements will be highly satisfactory. Everything, as usual, is under the same roof, and also on two floors of the Sherman.

We had more difficulty in arranging a meeting last year in Springfield than we had encountered in many years. The exhibits were fewer in number on account of limited space. This likewise affected some of the other essential functions for a successful annual meeting. Because it was necessary to build many settings for the Springfield meeting, the deficit was greater than it has been for any previous annual meeting. We are again fortunate this year in finding everything already constructed at the Sherman, and the expense of the meeting will be much less than we encountered a year ago in Springfield.

There was also a lower attendance than we had registered in many years, this causing some dissention on the part of the exhibitors whose interests must be considered in our planning, for they pay the major costs of the annual meeting each year. During recent months we have been considering the advisability of selecting the place and tentative dates for the annual meetings at least two years in advance, as is being done with many other societies today. This has been done for some years by the A. M. A., which selects the place of meeting three years in advance, both for the regular annual session and the midwinter clinical meetings.

The Council has considered this matter quite seriously, and you will no doubt hear more on the subject from the Chairman of the Council during this 1951 annual meeting.

THE HOUSE OF DELEGATES—Every component society, regardless of its membership, is entitled to representation in the House of Delegates during the annual meetings. Larger societies have additional

delegates according to their respective membership rolls. Under our By-Laws, every society is entitled to one delegate for each 75 members, and one for each major fraction thereof; but each component society which has made its annual report and paid is assessment as provided for in the Constitution and By-Laws, shall be entitled to one delegate.

A society, therefore, with 113 members is entitled to two delegates, and one with 188 members, three delegates. The large Chicago Medical Society consequently is entitled to one delegate for each 75 members, or "major fraction thereof." This question is frequently asked, especially by a society which has slightly more than 75 members, and which believes it is entitled to an additional delegate. However, the By-Laws are quite specific, and it is easy to determine which societies are entitled to additional delegates each year.

Our Society is a true democracy in that we have the executive, legislative and judicial divisions. The House of Delegates is the legislative body, while the Council represents the judicial division. Each component society should select its delegates carefully and be sure that members who are well informed and will attend the meetings are selected for this important undertaking. Frequently we hear of members going back to their local society to give a report on the transactions of the House of Delegates, and perhaps saying that everything seemed "cut and dried," and they only had the opportunity of voting yes or no on the many problems, resolutions and other matters coming before the House.

Unfortunately they overlook the fact that they are permitted and urged to bring matters before the House as requested by their own component society. Likewise, all matters are referred to reference committees for hearings and study. Delegates are urged to attend meetings of the proper reference committees to discuss anything of especial interest to them and their own society. By active participation in the many deliberations before the House of Delegates, they should be better enabled to give an interesting report upon their return home from the annual meeting.

MEMBERSHIP AND ANNUAL DUES—We have endeavored to give information on membership and dues through editorials and other releases published in the Illinois Medical Journal, through the Secretary's News-Letter, which is sent each month to all county society officers, as well as to other members desiring to have their names on the mailing list. Even so we receive many letters asking for information on these subjects each month.

The House of Delegates at the 1950 meeting in Springfield amended the Constitution and By-Laws of the Illinois State Medical Society to make it mandatory that any physician, in order to remain in good standing in his county and state medical society, must also pay membership dues to the American Medical Association. Frequently it has been called to the attention of the entire membership that for more than 100 years there were no annual dues required to maintain membership in the A. M. A.

This action was taken last year by the representatives of all component societies which constituted the House of Delegates. It could only be taken at the state level, as the American Medical Association in assessing annual dues of $25.00, did not make it mandatory that members in the county and state societies likewise hold membership in that organization. However, membership in that Association is contingent upon the payment of the $25.00 assessment.

Any physician paying county and state society dues must pay the A. M. A. assessment, or forfeit his membership. It is not possible to retain membership in a county society, and not pay dues for membership in this Society. Under our present By-Laws, A. M. A. membership is likewise mandatory. Physicians paying the A. M. A. assessment are now entitled to receive the Journal of the American Medical Association without additional cost. The subscription price to non-members for the J. A. M. A. is $15.00.

In Illinois the only physicians exempt from payment of county, state society and A. M. A. dues are *Emeritus and Past Service Members.* There is also a provision in the present A. M. A. by-laws to the effect that physicians who cannot qualify for Emeritus or Past Service ratings, and for whom payment of county, state and A. M. A. dues is an unusual hardship, may become exempt from their payment. However, it would be necessary to present the information to the State Society House of Delegates, and if acted upon favorably, the conditions and actions are submitted to the A. M. A. for similar action. The member, however, must be in good standing at the time the special exemption is requested. We have had a number of instances reported to our office where the county society pays the annual dues of some member unable to finance his own membership and who cannot qualify for either Emeritus or Past Service ratings.

The A. M. A. has ruled that when annual dues of members are not paid by December 31, they will be given one month to take care of the matter, and during this period they will receive a notice to that effect directly from the American Medical Association. If the deficit is not paid within the thirty-one day grace period, membership is cancelled at the county, state and A. M. A. levels respectively, after January 31.

We still receive letters from members of the Fifty Year Club, who have the impression that they are exempt from all dues, but this is not the case. If they have attained the age of 70, and have been members of the state medical society for 35 years, they may qualify for Emeritus Membership rating. If they cannot qualify for Emeritus Membership, and are unable to continue their practice, they may be elected to Past Service Membership rating. In both these types of membership, action must first be taken at the county level, and a request made that the State Medical Society take similar action. Then, if proper action is taken, the matter is referred to the American Medical Association for similar action.

This procedure is herein outlined in much detail to give factual information to the county society officers as well as the membership of this society as a whole.

THE COUNCIL—Once more we desire to pay our respects to the Council of this Society. Composed of men who devote a considerable part of their time for the interests of the Society, it is rare indeed that any member is absent from a meeting. Your secretary, who is also secretary of the Council, has attended every meeting during the past year, and our records show that he has not missed a single meeting of the Council during the past 29 years.

THE GRIEVANCE COMMITTEE—During the past year the Grievance Committee has been placed in operation, and this in our opinion is one of the most important developments of the year. It is quite obvious that not only the members of this society should be aware of the work of this committee, but the public as well should know that the Illinois State Medical Society has a committee which will do everything possible to make a thorough investigation, and right a wrong, if one actually exists. During the next year more information on the work of the committee will be available, and will be reported to the House of Delegates at the next annual meeting.

THE SOCIETY—Each year the Illinois State Medical Society has added new responsibilities to its previously long list. Certain committees have become more active than in previous years, and additional ones have been created for specific purposes. The Committee on Medical Service and Public Relations recommended to the Council that conferences be arranged in various sections of the state, at which medical public relations will be discussed.

With the postgraduate conferences, and other special meetings, in addition to the many other types of meetings which have been held throughout the state, it was deemed advisable to hold most of these special meetings early in the fall. The first of the series, however, was held in Decatur, March 27. There was an excellent attendance, and the meeting seemed to be well worthwhile.

In accordance with recommendations from the House of Delegates and approved by the Council, one speaker has appeared on each of the postgraduate conference programs to give a brief discussion of our Prepayment Medical Care Plans. We urge each member of this House of Delegates to read carefully the report of the Committee on Voluntary Prepayment Care Plans, which is printed in this handbook, and see what has been done in Illinois along the line of promoting policies to protect the laity against the costs of the unexpected or so-called "catastrophic" illness or accidents.

We are unable at this time to tell what effect on the society membership the mandatory membership in the A. M. A. will have. There have been some objections to the A. M. A. dues, and some members and a few county society secretaries have asked if it is still possible for a member to be retained on the membership list in good standing by paying only county and state society dues. The answer is quite obvious, as has been brought out previously in this report.

The response to April 30, the end of the fiscal year, has been quite encouraging, so far as collection of dues is concerned. We frequently are required to call to the attention of our component society secretaries that 1950 A. M. A. dues must be paid, before we are permitted to accept dues for the current year.

DEATHS OF MEMBERS—Death once more has taken its toll of members of this Society, as would be expected in a society of nearly ten thousand members. It is gratifying, however, to note that approximately one dozen of these were past the age of 90, and one of them nearly 95 years of age at the time of his death.

We are not able to name all of the physicians whose deaths have occurred since the last annual meeting, as necessary space is not available in this report. We will, however, refer to some of them, who have been quite prominent in the affairs of their component Society and the Illinois State Medical Society over a period of years.

I. L. Foulon, East St. Louis, graduated from Washington University Medical School in 1915; Secretary of the St. Clair County Medical Society for a number of years, President of the County Tuberculosis Association, and for many years active in both his county and the state society; died April 17, 1950, aged 61.

Harry S. Gradle, Chicago, graduated from Rush Medical College in 1908, Professor of Ophthalmology (emeritus) University of Illinois College of Medicine, for many years active in this and a number of other medical societies; died in California, May, 1950, aged 67.

Italo Frederick Volini, Chicago, graduated from Rush Medical College in 1917, professor and head of Department of Medicine at Stritch School of Medicine of Loyola University, active in the affairs of this society for many years, appearing on annual meeting, postgraduate and many other society programs; died while attending the A. M. A. meeting in San Francisco, June 24, 1950, aged 57.

Frank J. Smejkal, Chicago, graduated from University of Illinois College of Medicine, 1926, Associate Professor of Medicine, Chicago Medical School, member of the State Tuberculosis Board, and for a number of years active as a member of the State Society Committee on Tuberculosis; died August 4, 1950, aged 60.

Effie L. Lobdell, Chicago, graduated from Fort Wayne College of Medicine in 1892, an outstanding woman physician of the nation, and active in this and other societies; died August 8, 1950, aged 83.

Harold E. Jones, Chicago, graduated from Northwestern University Medical School, 1909, senior attending surgeon at St. Luke's Hospital, Chicago; died July 10, 1950, aged 63.

Charles E. Eisele, East St. Louis, graduated from St. Louis College of Physicians and Surgeons, 1905, President of Southern Illinois Medical Association and St. Clair County Medical Society; died August 28, 1950, aged 68.

William F. Peterson, Chicago, graduated from Rush Medical College, 1912, Director, Department of Clinical Research, St. Luke's Hospital; died August 20, 1950, aged 63.

Emmet Keating, Chicago, graduated from Rush Medical College, 1903, past president, Northwest Branch of the Chicago Medical Society, very active in this Society for many years, died September 16, 1950, aged 78.

Fred S. O'Hara, Springfield, graduated from Marion-Sims College of Medicine, 1899, first president of the Radiological Society of North America; died October 1, 1950, aged 74.

Brig. General Benedict Aron, Chicago, graduated from Chicago College of Medicine and Surgery, 1916, formerly surgeon-general, Illinois Reserve Militia; died December 7, 1950, aged 63.

Carl B. Davis, Winnetka, graduated from Rush Medical College, 1903, formerly professor of Surgery, University of Illinois College of Medicine; died December 11, 1950, aged 73.

Stanley R. Walker, Chebanse, graduated from Queen's University Faculty of Medicine, Kingston, Ontario, 1889; prominent in the Kankakee County Medical Society, many times a member of the House of Delegates of this society; died December 1, 1950, aged 87.

John H. Edgcomb, Ottawa, graduated from University of Illinois College of Medicine, 1906, long active in his county and this society, for many years member of the House of Delegates, died in automobile accident, February 12, 1951, aged 66.

James S. Mason, Urbana, graduated from Northwestern University Medical School, 1894, very active for many years in his county and this state society; died January 8, 1951, aged 82.

Fred C. Zapffe, Oak Park, graduated from University of Illinois College of Medicine, 1896; died March 10, 1951, aged 77.

William H. Maley, Galesburg, graduated from Rush Medical School, 1897, for many years active in his own Knox County Medical Society, and the Illinois State Medical Society. Dr. Maley was a familiar figure in the House of Delegates, where he served for many years. He invariably wore his red neck tie each day of the year except on St. Patrick's Day. Always active in civic affairs, and served in many capacities in Galesburg over a long period of years; died March 7, 1951, aged 84.

Frank Buckmaster, Effingham, graduated from Barnes Medical College, 1899, for many years an outstanding surgeon in his area, active in county and state medical society; died March 3, 1951, aged 76.

F. H. Maurer, Peoria, graduated from Rush Medical School, 1915, a former president of Peoria County Medical Society and who served as an officer of the Section on Pediatrics of this Society, died April 22, 1951, aged 61.

Other prominent members who died since the last annual meeting are: S. Frank Russell, Macomb; Frederick C. Hamilton, Kankakee; Wilbur C. Wood, Decatur; Clarence F. G. Brown, Chicago; Benjamin D. Jenkins, Macomb; John R. Porter, Rockford; Joseph A. Jerger, Chicago; L. J. Weir, Marshall; E. F. Gollobith, Hanover; Armina Sears Hall, Chicago; Clarence A. Fortier, Kewanee; Maurice Dow, Chicago; Albert H. Carter, Oak Park; John A. Graham, Chicago; Roger T. Vaughan, Chicago; Henry S. Sherman, Chicago; R. G. Empson, Valmeyer; Dwight Freeman Clark, Evanston; William T. Harsha, Chicago; Frederick Menge, Chicago; Clarence A. Neymann, Chicago; James M. Mitchell, Oblong; O. J. Flint, Princeton; Robert H. Graham, Aurora.

We should pay our homage to these fine physicians at this time. Most of them had not retired but were practicing until a short time before their death. A number of them died from accident while carrying on their duties in caring for the afflicted. They will long be remembered in their respective communities for their efforts over a long period of time as physicians, and members of various civic activities. Records of the achievements with appropriate bibliographical data will be retained in the archives of the Illinois State Medical Society.

In closing this report we again desire to thank the officers of component societies for their splendid cooperation throughout another fiscal year. The Society should likewise thank the members of committees, speakers who have participated in the many postgraduate conferences, and those who have appeared before county societies throughout the state.

Your Secretary also desires to pay his respects to the fine force in his offices both in Monmouth and in the Society's Chicago office. We have indeed been most fortunate for many years in having loyal assistants who frequently work overtime without any criticism or complaint. Most of them work five and one-half days each week, although our office is open six full days of each week. We are always glad to have members come in and get better acquainted with our duties, and to meet the force of employees always on hand.

MEMBERSHIP DATA—The overall membership on April 30, 1951, was almost identical with that reported to the House of Delegates one year ago. We have new members admitted each week from somewhere in Illinois, then of course, we have members lost by death, removal from the state, and occasionally a resignation, although there were only 14 who resigned during the entire year from May 1 to April 30, our fiscal year.

Members in Good Standing as of April 30, 1950	9,869
Added during the year:	
New Members	422
Reinstatements	59
Total added for the year	481
Total	10,350
Dropped during the year:	
Died	140
Moved away	197
Resigned	14
Non-payment of dues	139
Total dropped for the year	490
Membership as of April 30, 1951	9,860

FINANCIAL REPORT OF THE SECRETARY-TREASURER

Receipts from County Societies

Adams	$ 1,410.00
Alexander	220.00
Bond	120.00

Boone	0.00
Bureau	640.00
Carroll	220.00
Cass	330.00
Champaign	2,000.00
Chicago Medical Society	104,222.50
Christian	580.00
Clark	395.00
Clay	140.00
Clinton	300.00
Coles-Cumberland	936.00
Crawford	0.00
DeKalb	435.00
DeWitt	180.00
Douglas	320.00
DuPage	2,240.00
Edgar	20.00
Edwards	80.00
Effingham	300.00
Fayette	180.00
Ford	260.00
Franklin	460.00
Fulton	600.00
Gallatin	100.00
Greene	0.00
Hancock	80.00
Hardin	0.00
Henderson	120.00
Henry	740.00
Iroquois	555.00
Jackson	580.00
Jasper	80.00
Jefferson-Hamilton	990.00
Jersey	160.00
Jo Daviess	261.00
Johnson	80.00
Kane	3,315.00
Kankakee	1,405.00
Knox	1,085.00
Lake	2,615.00
LaSalle	1,860.00
Lawrence	240.00
Lee	540.00
Livingston	1,100.00
Logan	535.00
McDonough	520.00
McHenry	130.00
McLean	1,920.00
Macon	1,890.00
Macoupin	880.00
Madison	2,245.00
Marion	1,240.00
Mason	120.00
Massac	140.00
Menard	80.00
Mercer	60.00
Monroe	220.00
Montgomery	440.00
Morgan	780.00
Moultrie	230.00
Ogle	440.00
Peoria	3,640.00
Perry	280.00
Piatt	200.00
Pike	260.00
Pope	0.00
Pulaski	90.00
Randolph	360.00
Richland	260.00
Rock Island	2,140.00
St. Clair	2,320.00
Saline	600.00
Sangamon	3,080.00
Schuyler	120.00
Shelby	270.00
Stephenson	700.00
Tazewell	895.00
Union	220.00
Vermilion	220.00
Wabash	240.00
Warren	400.00
Washington	140.00
Wayne	0.00
White	420.00
Whiteside	1,435.00
Will-Grundy	2,100.00
Williamson	20.00
Winnebago	3,400.00
Woodford	220.00

Total	$168,394.50
General Fund	$126,090.25
Benevolence Fund	42,304.25
Total	$168,394.50

RECEIPTS AND PAYMENTS

Fiscal Year Ended April 30, 1951

Receipts

Component Societies:		
General Fund		$126,090.25
Benevolence Fund	42,304.25	$168,394.50
American Medical Association Dues		209,044.25
Subscriptions—Journal		417.90
Advertising—Journal		67,699.22
Exhibits—State Meeting (1950)	1,550.21	
Exhibits—State Meeting (1951)	7,385.00	8,935.21
Interest—Government Bonds		2,250.00
Dividends—C. & N. W. R. R.		46.50
Liquidating Dividends—Sheridan Tr. & Sav. Bk.		160.03
American Medical Association—Collection Serv.		3,426.69
Miscellaneous and Refunds		218.50
Total Receipts		$460,592.80
Cash Balance, May 1, 1950		93,343.72
Total		$553,936.52

Payments	
Secretary's Office Expense	$ 30,545.84
Council Expense	12,049.81
A. M. A. Meeting Expense	7,159.15
State Meeting Expense	17,572.27
Legal and General Counsel Expense	500.00
Journal Expense	63,912.86
Fifty Year Club Expense	223.63
Committee Expenses:	
Advisory Committee to Illinois Public Aid Com.	10.00
Advisory Committee to United Mine Workers	127.00
Committee on Archives and Medical History	1,263.63
Educational Committee	21,059.48
Committee for Improvement of Care of Patients	2.45
Committee on Voluntary Prepayment Plans	126.56
Maternal Welfare Committee	649.32
Medico-Legal Committee	15.88
Committee on Medical Service and Public Relations	32,272.12
Committee on Medical Testimony	69.46
Committee on Military Affairs and Emergency Medical Service	404.41
Nutrition Committee	47.37
Postgraduate Committee	2,056.59
Committee on Military Affairs	780.13
Committee on Rural Medical Service	667.21
Scientific Service Committee	523.38
Tuberculosis Committee	179.39
Women's Auxiliary	475.72
Social Security Taxes	475.40
State Unemployment Insurance Tax	78.40
Federal Unemployment Insurance Tax	92.14
Chicago Medical Society—Services Rendered	889.24
American Medical Association—Dues	209,044.25
Benevolence Fund Printing	24.35
Transfers to Benevolence Fund	42,304.25
Total Payments	$445,601.69
Cash Balance, April 30, 1951	108,334.83
Total	$553,936.52

Respectfully submitted, HAROLD M. CAMP, M.D., *Secretary-Treasurer.*

FRED N. SETTERDAHL
Certified Public Accountant
224 Robinson Building
Rock Island, Illinois

To the Members of the House of Delegates:

CERTIFICATE OF AUDIT

I have audited the following accounts of your Society for the fiscal year ended April 30, 1951:

Secretary's Office—Dr. H. M. Camp, Secretary.
Journal Office—Mr. L. E. Malley, Manager.
Educational Committee—Miss Ann Fox, Secretary.
Benevolence Fund—Dr. H. M. Camp, Secretary.

Dues received from Component Societies have been verified with duplicate receipts, and the Master Ledger Cards of each Component Society were compared with the Secretary's report.

Receipts shown include amounts received for the Benevolence Fund and the American Medical Association. The receipts for the Benevolence Fund are transferred to a separate bank account and the A. M. A. Dues are remitted to the American Medical Association.

Receipts from Journal advertising have been verified with the records and reports of the Manager, who receives and remits same to your Secretary.

Bond Interest received was compared with interest due on bonds. Other receipts consist of Exhibit Rentals, Journal Subscriptions, Refunds, etc., which have been taken into account as recorded.

During the year an additional liquidating dividend was received from the Sheridan Trust and Savings Bank, amounting to $46.50. This was a bank deposit claim of the Educational Committee Funds and the Journal Funds, which were on deposit when the bank closed.

All receipts are recorded on the Secretary's records and are deposited in the depository bank.

Payments are made by check and are supported by approved vouchers, orders, etc.

The cash balances were reconciled with the depository banks.

The Society has funds amounting to $90,000.00 invested in U. S. Government Bonds, which are issued in the name of the Society. The Society also has 31 and 70/100 shares of common stock of the Chicago and Northwestern Railway Company. These shares were issued in lieu of bonds formerly held.

The accounts of the various departments have been well kept and, in my opinion, your Secretary's Financial Report presents the transactions for the year.

The Council will be furnished with a detailed audit report, which agrees in totals with your Secretary's report.

Respectfully submitted, FRED N. SETTERDAHL, *Certified Public Accountant.*

REPORT OF THE CHAIRMAN OF THE COUNCIL

The work of your Council during the past year has been quite voluminous. The character of the work has been exceedingly varied. It has been concerned in many instances, with matters of policy that are of particular interest, even to each of us as private practitioners.

During the year the Council has convened seven times. The organization meeting was held on the final day of the annual Assembly last year in Springfield. The second meeting was held in the Palmer House and the five subsequent meetings have been held in the Hotel Sherman. These sessions are held on Sunday morning and begin at 9 o'clock. Lunch is served at 12:30 and very often from thirty to forty-five minutes of work is necessary after finishing the lunch. All except the last were regular meetings of the Assembly. The last

meeting on April 8th was called for the express purpose of considering the current demands of the Osteopaths.

The attendance of the Councilors has been excellent. The majority of the members have missed no meetings at all. Others have been absent only once and then because of absolute inability to be present. These Councilors as individuals are indeed worthy, and deserve the commendation and thanks of the House of Delegates for the sincere and honest effort that they have given unstintingly of time and strength of the business of organized medicine in the State of Illinois.

The Council has functioned smoothly and efficiently. Because of the volume and the complexity of the matters to be considered, most of the work is assigned to some particular committee, to digest and report concerning their thought as to the advisability of action on the part of the Council.

There are quite a number of committees organized within the Council and each committee has functioned conscientiously and efficiently. Matters referred for the most part to the individual committees have been received by the committee and action has been obtained by them and the report returned to the Council very expeditiously.

Dr. Harold M. Camp, Secretary of the Illinois State Medical Society is *per se* the Secretary of the Council. The amount of work that is accomplished by Dr. Camp and the assistants in his office is tremendous. He prepares the data for all matters that are to be considered by the Council and is able to present the facts concerning whatever problem may be under consideration, either to any committee or to the Council itself. Your Chairman hereby wishes to express his most sincere thanks to Dr. Camp for his kind and considerate assistance during every minute of the past year.

In a business way a new policy has been introduced. The purchasing of all materials by the Society for use in either of the offices in Monmouth or in Chicago is made by a single agent. Another item, no expenditures are entered into by any officer or member of the organization without first having been submitted to, and having been approved by, the Finance Committee. This as well as some other endeavors has enabled the Finance Committee to become an entity with authority, and it no longer perfunctorily functions in "O. K.'ing" bills already paid.

The proceedings of the House of Delegates at last year's annual Delegates meeting and also excerpts from the proceedings of most of the Council meetings have been reported in the Journal. This has proven quite interesting and informative to the individual members of the Society. This procedure was entered into with the thought that if the individual members of the profession read something of what was done in the Council, they might become aware of the amount of work and the many intricate problems that are done for them by their Councilors.

Early this year the Council proceeded on another task in order to save time on matters that required action in the interim between Council meetings. Dr. Camp, Secretary, was made Executive Secretary of the Council with power to evolve a policy on any matter that required immediate action. And for his help in this particular endeavor an Advisory Committee was named, consisting of the President, the Chairman of the Council and the Chairman of the Finance Committee. While this method has not been used often it has served on one or two occasions, to expedite matters that required prompt action.

Both as a matter of Public Relations and as a matter of information concerning all business and professional activities in the State, it was deemed advisable that the Illinois State Medical Society should become a member of the Chamber of Commerce of the State of Illinois, and this was accomplished.

One of the Councilors from the Third District, Dr. Prather Saunders, found it necessary to discontinue his work with the Council for personal reasons, particularly because of his health. In August his resignation was accepted with great regret by the Council. As is provided in the Constitution and By-Laws the Council proceeded then to name a successor to Dr. Saunders. Dr. John R. Reichert of Chicago, was chosen to this position for the remainder of the fiscal year.

An item that has this year become of great interest to a large number of the members of the Illinois State Medical Society has been the question as to their status in the Military Service of the United States. It has been very fortunate for the Illinois State Medical Society that Brig. General Carl F. Steinhoff was the Chairman of the Medical Officer Procurement Service for Illinois and in this capacity meets with the Illinois Selective Service Administration and Medical Service group in the 5th Army Headquarters. His Secretary has office space in the Headquarters of the Illinois Selective Service System, a fact which makes for efficiency.

Dr. Steinhoff has been a practicing physician in Chicago and quite active in the Chicago Medical Society. He was chosen by the Council to represent the Illinois State Medical Society in its dealings with the Military until such time as a definite organization would be set up for the selection of physicians, such as was used in the last war to determine essentiality. Dr. Steinhoff has been very attentive and very efficient in this most difficult position, steering to procurement men who are in every sense eligible for military service and also in securing releases for those men who are in no sense eligible but who have been placed in a priority position in error. He has attended each of the Council meetings since his appointment and has been very receptive of any suggestions that might be for the betterment of the work and has been very anxious to reply to all qustions that might be asked him or sent to him.

Since the Chicago Medical Society was contemplating a change of location for its office, the question arose as to whether or not the Illinois State Medical Society might consider changing its Chicago offices which are at present located on the 14th floor at 30 North Michigan. At the January meeting of the Council it was decided that no change would be made, at least for the immediate future.

An item that must be brought to your attention is the cordial relationship that exists between the executive offices of the Illinois Public Aid Commission and the Illinois State Medical Society. Our Advisory Committee to the I. P. A. C. is composed of five physicians appointed by the Council for the purpose of presenting the problems arising in the Doctor's actual daily practice in this portion of his daily work and for advising the Commission as to our ideas of the questions involved. This Advisory Committee meets at least five or six times each year with those officials of the I. P. A. C., who deal with the program involving medical activities. At this meeting all the varied problems that are encountered in the Old Age program, the Dependent Children, the Blind and the complete disability program, are brought up before this Advisory Committee of physicians. Discussion is quite informal, often very specific and always thorough. The I. P. A. C. officials are very receptive to all suggestions as to the actual solution, and their action usually conforms to the suggested solution. We may not like the Old Age program, but in Illinois we have it carried on for us, in the very best manner that your elected representatives can determine. And this is by no means true in many other states.

This has been an admirable arrangement for both the I. P. A. C. and for the medical men of Illinois. In January of 1951, the tenth year of this amicable relationship was completed, and a small celebration was carried out in memory of this occasion. All of the physicians who had at any time served in this Advisory Board were invited to a dinner at the Sherman Hotel. That evening the Society was presented with a plaque inscribed with the names of the medical men who had been active on the Board, and setting forth the idea of the relationship. I am quite sure that this active committee will report in detail concerning its work this past year in this handbook. May I urge that all members of the profession in this state acquaint themselves to a better degree with the work of this Advisory Committee to the Illinois Public Aid Commission.

A problem that has as yet not been solved and has presented itself on at least two different occasions to the Council this year is that of the extreme need of physicians in welfare work and in our State Institutions. These Institutions are woefully understaffed. The question is a vital one and the situation is critical. Some states have been able to solve this problem to a certain degree by "limited licenses" for the men entering into this particular line of work. This has not seemed advisable, as yet anyway, to the Illinois physicians. This matter has been recognized as urgent by the Council and has been referred by them to the committee on Medical Service and Public Relations. This committee, no doubt, in the near future will be able after study and evaluation to offer something for the relief of this rather sorrowful blot on the present record in Illinois.

A continuation of and furthering of the plan of prepayment insurance has been going along at a good pace this year. New commercial carriers have been added to the lists that are selling this type of insurance under the "Illinois Plan" and the establishment of the Blue Shield Organization as a state-wide organization, which was formerly merely for Chicago, has enabled the enrollment of many thousands of additional people under the prepayment plan. This committee and especially its Chairman, Dr. Percy Hopkins, are particularly to be congratulated on the initiative work and the intensity of the work which they have continued to carry on. The work undertaken and accomplished this past year has been very great. This committee has the able assistance of Mr. John Neal, as Secretary, in the capacity of legal Counsel for the Illinois State Medical Society and Mr. James Leary as Public Relations Counsel. They accomplished almost the impossible, the first half of this present fiscal year, as you all know. Their work because of the lack of the brass band accompaniment is perhaps not well enough appreciated by the individual physician. Their efforts, however, have been most opportune, especially in its timing for effectiveness.

Their present program for acquainting the component societies with the manner and scope of the labor that is necessary to carry on an organization such as the Illinois State Medical Society has been in effect since the beginning of this year. This program is being well received and certainly can fill a long felt want on the part of the individual in that their knowledge of the organiaztion to which they belong is too often very limited and quite desultory.

In that part of the Educational program of the Society as carried on by the Educational Committee, a very fine record was attained this year. The Television shows which have been produced each week by the Educational Committee for the past nineteen months, were awarded a trophy of Excellence as determined by the readers of the magazine "TV Forecast." This show which is known as "Health Talk" was accorded first place in a vote by the subscribers of this magazine in which over 40,000 votes were cast for the year 1950. This gold statue award was given to the Illinois State Medical Society on one of the TV shows and was accepted for us by Dr. Harry Hedge, president of the Society. The other activities of this committee have been carried on very energetically and sucessfully. In no part of their program have they diminished their former prestige. This committee has the very able assistance of Miss Ann Fox as Secretary. The success of the past twelve months is largely due to the acumen of Miss Fox.

The annual meetings of the Illinois State Medical Society have for many years maintained a very high standard. This standard has been high in the Scientific presentations. It has been continued year after year at not too great expense to the Society. The management of these meetings is a job of no small volume and requires preparation of minute detail almost beyond imagination. This annual meeting compares well with those of other large State Societies. The 1951 Assembly will be no exception and with the Chicago Medical Society as host and Dr. Fred Muller and his arrangement committee in active charge, success is assured. Because of the increasing difficulty in securing sufficient hotel accommodations for housing the Annual Meeting, and because of the great number of other such conventions held in Chicago, it would facilitate arrangements greatly if place and date of such meetings could be "set up" two years in advance. With these facts before you, the Chairman of your Council recommends to the House of Delegates that they authorize the naming of the places for meeting in 1952 and 1953 in this meeting of May, 1951 and that they authorize the Council to fix dates for these two years. Thus carrying on as formerly, but arranging for two years in advance instead of for only one year.

Perhaps one of the most practical steps taken this year toward gaining public favor for our profession was the establishment of a Grievance Committee. Because this body can, theorectically and also practically combat many of the charges made against us as physicians, often as to excessive fees, etc., it would seem highly advantageous to make known to the public that we have a body, at County and State level which is set up to learn their points of dissatisfaction and to study them sincerely with the idea of arriving at a just conclusion. Dissemination of the fact that we are maintaining a Grievance Committee is recommended.

Sometime one is fearful that many members are of the opinion that this Society conducts its business meetings in the House of Delegates with a cut and dried high handed manner. Such is not the case at all. Every component society has its representatives in this meeting. Each delegate has equal privilege with every other delegate. Any delegate may bring any subject before the House. By offering a resolution a delegate is assured that before a reference committee he may present argument for or against and can help the committee in reporting it back to the House. And here again any delegate may discuss the committee's action in open forum. The plan is democratic. The delegates are urged to appear before reference committees to consider subjects on which their component societies are desirous of obtaining action by the House.

The consideration by your Council at its April meeting of the Osteopathic profession's relationship to the medical practice act of Illinois was a most interesting session. The meeting was a closed one. All possible points of view were presented, and all related subjects were investigated. The consideration was quite thorough. It was without prejudice. The decision arrived at was attained only after deliberation and was a sincere statement of the unamimous opinion of those present.

A fact that is indeed pleasing and gratifying is the fact that the Director of the State Department of Public Health, Dr. Roland Cross, has attended all the regular Council meetings. He was very ably assisted in the clarification of many problems and his advice is valued by the Council. This amicable liaison with the State Department is indeed worth while for both parties.

The selection of Dr. E. E. Davis, as the outstanding general practitioner in Illinois for 1951 was indeed a happy one. The honor conferred by this selection was justly awarded. The quality of work done by Dr. Davis over many years as a general practitioner has been excelled by very few, if at all, and not even equaled by many. His work at the present time ranks second to none in quality and the record of "his" hospital speaks volumes for him and is a well merited pedestal to establish his fame as "outstanding." His selection was made by a committee, the personnel of which is known only to the President and the Secretary.

The work of the Auxiliary to the Illinois State Medical Society has this year been very progressive all over the state. Many of the component societies acquitted themselves well last fall in their efforts against Socialized Medicine. Several new ventures have received their attention and their ship is making a decided wake as evidenced by their accomplishments and is not just sailing complacently and going nowhere.

The Committee on Military Affairs and Emergency Medical Service has been exceedingly busy this past year. To it was assigned the development of the medical phase of Civil Defense. This committee has worked with the State Director of Civil Defense Plans for Illinois, who was appointed by the Governor, and also with the Department of Public Health. The magnitude of their work is only known after one has surveyed the plan as set up for the State. Each component society has received detailed publications of this work; and each Society should be, and must be, thoroughly awake to the position the Society and each physician must fill competently if any war catastrophe comes. It is urged that each delegate returning to his local organization shall so thoroughly report on this Defense Plan that every one of our members will acquaint himself with his duties in its operations.

In September of this past year the Council was informed that the United State F. B. I. has been ordered by the Department of Justice to investigate the Illinois State Medical Society. No definite reason was ascertainable for such action. However, it is to be remembered that chronologically an election was soon to be held; an election of great importance to the politicians then in office and an election of great import to the physicians, especially of Illinois. It

is to be remembered also that we were at that time "in a shooting war" and that in such a time, as well as for many other reasons, the demand on the services of the F. B. I. was quite heavy for investigating matters of national significance and even of national safety. Nevertheless the activities of the I. S. M. S. were so investigated. This investigation was quite realistic and exceedingly thorough, carried out by three agents who were very courteous and true gentlemen. For the most part of the time during which they worked in the office of our Secretary, —our legal Counsel, Mr. John Neal, was present. Every record of every sort, all publications of the Society and even files of insignificant items were scrutinized. To date no hint even has been learned by anyone as to what might have been "turned up," by this time-consuming investigation (and expensive to the tax payers). In spite of the unanimous belief on the part of the Council, that we were as a Society in no way transgressing any precept, custom or law, it was deemed best to accede to the demand to placidly allow the investigation. The Department could have, of course obtained a court order for such procedure had we opposed their coming in. The whole affair is quite disconcerting to one as a citizen, to know that the lime light can be turned on *innocent* activities whilst gross defects and transgressions are thereby as least for the time being allowed to proceed in the shadow.

The Committee on Rural Medical Service has as usual been definitely engaged in furthering the position of, and incerasing the efficiency of "medicine" in Illinois. Their effectiveness in accomplishment is evidenced by the progress of their program in establishing students in the University of Illinois who are slated to return to communities needing physicians. There are twenty-seven of these students at present.

It is quite evident to all that the Illinois Medical Journal has stepped up its tempo remarkably in the past twelve months. The editorials have been well written, and have contained "live" reading for our members. The subject matter of articles published has been interesting and quite scientific. The editors have had a wealth of papers submitted for use, and the voluminous backlog of available material for the future, speaks well for the excellence of our Journal. The general appearance of our publication and its format have changed to a much more modern type. The editors, their editorial board, and the Journal committee are to be congratulated. The financial position of this activity of the Society, is well in the blue ink of our ledger. Mr. L. E. Malley as business manager, has accomplished a fine piece of work. He is to be commended for this and should receive our wholehearted thanks.

The Scientific Service committee and the Postgraduate Education committee have both been diligently active. Each has filled a decided need in the programs proposed for all sections of the State. It seems to the Chairman of the Council that one or the other of these committees should be authorized by the House of Delegates to establish some sort of clearing house for scheduling meetings dealings in any way with our profession. Other organizations could be asked to join in this endeavor. By such, the chance of having two meetings in the same area, at about the same time could be avoided. And, if directed, by the House of Delegates to do this, perhaps other groups would be more likely to approve and assist in this endeavor.

May we direct your attention to the great amount of work for the I. S. M. S. accomplished by the following individuals:

Mrs. Frances Zinmer as the Secretary's Assistant.

Dr. Theodore Van Dellen as Moderator on the TV shows.

Mr. John Neal as legal advisor.

Mr. James Leary as Public Relations Counsel.

Miss Ann Fox as Secretary of the Educational Committee and Director of the TV shows.

In an organization such as the Illinois State Medical Society of necessity there are many committees which must be active in order that the Society may function thoroughly. Some of these committees deal with problems that do not bring them into the spot light. These efforts are just as essential to our welfare as are those of any other committee. Commenting on their accomplishments in this report is superfluous, since reports of their activities are recorded in this handbook, to which you are referred.

It seems to your Chairman that during this year the attitude of the individual members, to the Council itself, to the Chairman of the Council, and to each other, has been one of friendliness, of definite concern and with the interests of the I. S. M. S. paramount above all else. Expression of thanks from the Chairman to each of the Councilors, and to the members of various committees is officially expressed and sincerely given.

Respectfully submitted, CHARLES P. BLAIR, M. D., *Chairman of the Council.*

SUPPLEMENTARY REPORT BY THE CHAIRMAN OF THE COUNCIL

Your report in the handbook from the Chairman of the Council emphasizes one item, a proposal which we expect to give you now and which we expect you to pay a good deal of attention to, for I am sure you are very much interested.

As Chairman of the Council, I am bringing you this supplementary report at this time in order that you, the Delegates of the House, might have better and complete information concerning the recent demands that are made by the Osteopathic profession.

The State of Illinois through the Department of Registration and Education, through the medical division of this department, licenses candidates with the degree of M.D. and Osteopathic candidates and Chiropractic candidates under the medical practice act of 1923; that is, the original medical practice act was amended in 1923 and has not been changed since that time. Under this legislation, the board

of examiners is composed of a five man board, all M.D.'s, appointed by the department. In addition to these five, there is one Osteopath and one Chiropractic adviser who conduct the examination for the candidates in their particular category insofar as actual practice is concerned. As this board has functioned for some years, these two men, the Osteopath and the Chiropractor, sit with the board and have an opportunity to express their opinion on all matters but they have no vote. In other words, questions coming before this board concerning policy or licensure are determined by the five medical men.

Under the present legislation any candidate for license either Osteopath or Chiropractor may be permitted to take the complete examination for unlimited license if the candidate can furnish information in regard to his education and preparation that meets the requirement of the board. To date, no candidates have applied for this unlimited license from either the Chiropractic Schools or the Osteopathic Schools. So much for these facts which are now in operation.

Early in 1951, the National President of the Osteopathic Association had occasion to meet and spend some time with Dr. Henderson, the present President of the American Medical Association. In their discussion, in Louisville, it became evident to Dr. Henderson that perhaps the Osteopaths had a cause sufficient for recognition, at least for discussion by the A.M.A. Consequently, a meeting was arranged with certain of the A.M.A. officials and certain of the Osteopathic officials, at which the situation was discussed. After consideration, it was decided that the present situation in Illinois was not one for the A.M.A. to consider and it was recommended that the Illinois State Medical Society investigate the request or demand of the Osteopathic profession.

With this in mind the President-Elect of the American Osteopathic Association, on the 20th of February of this year, contacted a friend of his in Chicago who is quite prominent in the Chicago Medical Society and in the Illinois State Medical Society. After this talk, the physician verified the statements that had been made by the osteopath and since they were correct, he then talked to some of the officials of the Illinois State Medical Society about this matter and on March 2nd, a small group of medical physicians and a similar group of Osteopathic physicians met together and discussed the problems that had been presented previously at the A.M.A. meeting. There was nothing official about this meeting whatever as both groups understood.

At the regular meeting of the Council of the Illinois State Medical Society on March 4th, this matter was brought before the Council and authorization was given to the Committee on Medical Service and Public Relations to have further meetings with the Osteopathic group and see what could be done concerning their demands or requests. Such a meeting was held on March 7th. At this meeting, which was the first formal meeting, we learned several things. First, it had been necessary for the Osteopathic group to take action in court before the limit of time expired and to appeal from the decision of the Board of Examiners of the Department of Registration and Education in connection with the approval of their school, the Chicago Osteopathic College. This school had been examined by the board of medical examiners in 1949 and was found not to meet its standards for preparation of students to enable them to take the "full" examination for unlimited practice. This finding was concurred in by the Department of Registration and Education. For various reasons the Osteopathic Association requested a second examination of their Chicago College. This, the department agreed to and again a survey of the Chicago College of Osteopathy was made by the medical examining board, which, at this time, consisted of two new members—in other words, six medical men, not just five, made the examination. A second time the examiners were of the opinion, unanimously, that the Chicago Osteopathic College did not meet the standards required of medical schools for eligibility to be admitted to the examination for unlimited license. The Department of Registration and Education again concurred in the opinion of its medical examining committee. Following the receipt of this decision, the Osteopaths asked for a hearing of their case before the Department. This was agreed to and the Osteopathic group appeared before the administrator of the Department and the medical examining board, stated their case, recounting wherein they thought the previous decisions were in error and affirming many points as to why they thought the Chicago College should be recognized. Their attorney was present and they were allowed to present any evidence they had in mind, with no restrictions from those hearing the case. Following this appeal, the Department and its medical examining board, after again thoroughly considering all evidence and argument, decided again that the College of Osteopathy in Chicago was inadequate for the preparation of candidates to take examinations for unlimited license. The osteopaths stated that this action in court would offer no obstacle to further consideration of their problem.

Second, we learned (if it were possible) that the Osteopathic group desired and literally demanded approval of their school. Third, the "grandfather clause", which provided that their graduates after three hundred hours of additional study be allowed to take the examination for unlimited license was a part of their demands. Fourth, a request was made for a separate board of examiners to be set up for the Osteopaths.

Following these official meetings in which the above facts had been arrived at, it seemed advisable to the Committee on Medical Service and Public Relations that a meeting be set up with the Board of Examiners. A meeting with the Board of Examiners was impossible because the Board stated it

did not want to meet without a full membership and in the absence of Dr. Hamilton, who was Chairman of the Board, this would be impossible.

It then seemed to our committee that the next thing was to have the Council go over this matter very thoroughly in executive session and determine what course should be pursued further. Such a meeting was set for April 8th.

The Osteopathic group was quite familiar with our intention of having this meeting and of arriving therein at a conclusion if possible, as to what attitude we might have or what we might be able to offer them in place of their proposed legislation. Because of the time element and because of some of the more radical members of their profession, the Osteopaths were able to have introduced into the Senate at Springfield three separate bills, Nos. 267, 268 and 269. The Osteopathic group were thoroughly aware of the fact that we the medical men of Illinois were opposed to this legislation which was introduced in the above three bills.

The meeting of the Council which was held on the 8th of April was very well attended. The two Councilors who were unable to attend had forwarded their opinion as to the matter, that it might be expressed to their fellow members. All the physicians present and also Mr. Neal, the Legislative representative, spoke during this session concerning their ideas and the opinion of their particular geographical area concerning the proposition which had been arrived at and presented to the Council by the committee.

All aspects in the various ramifications of this problem were presented before the Council by the various members and the discussion was very free and each man expressed his opinion very sincerely. As stated, the Council met in executive session with only the following men who are not members of the Council present, Dr. Jacob E. Reisch of Springfield, Frst Vice-president; Dr. A. J. Linowiecki of Chicago, Second Vice-president; Dr. Percy E. Hopkins of Chicago, Chairman of Committee on Medical Service and Public Relations; Dr. James H. Hutton of Chicago; Dr. Everett P. Coleman of Canton; Mr. Neal, legal representative; and Mr. James C. Leary, Public Relations Director. After several hours of discussion the Council was unanimous in expressing its opinion that: First, the Illinois State Medical Society through its Council definitely and unalterably opposed Senate bills Nos. 267, 268 and 269. Second, the Medical Examining Committee was not at fault in refusing to approve the Chicago College of Osteopathy and that the Council should express its confidence in this examining committee for its action. Third, a composite board might be advisable, composed of five medical men, one Osteopath and one Chiropractor, all being duly licensed to practice in the State of Illinois. Fourth, the Council would establish a special liaison committee, to confer with, and to work with, the representatives of the Illinois Osteopathic Association, to the end that the physical facilities, curriculum and faculty of the Chicago College of Osteopathy may as quickly as possible be improved to a point where the school can be approved as qualified to teach medicine in all of its branches in accordance with present standards of medical education. The vote on these points was unanimous. As a result of this the Chairman of the Council was instructed to forward to the president of the Illinois Osteopathic Association the following resolution:

Whereas, The Chicago College of Osteopathy has made application to the Illinois Department of Registration and Education for approval by the Department, under the Medical Practice Act of Illinois, as a school qualified to train applicants for licenses to practice medicine in all of its branches in this state, which application was recently disapproved by the Department; and

Whereas, Proceedings for judicial review of that order of disapproval are now pending in the Superior Court of Cook County; and

Whereas, Senate Bills Nos. 267, 268 and 269 have recently been introduced into the 67th Illinois General Assembly at the request of the Illinois Osteopathic Association, which bills seek the establishment of a separate Board of Osteopathic Examiners within the Department, which would have authority to inspect and approve the Chicago College of Osteopathy as a medical school, as well as to permit former graduates in osteopathy to qualify for an unlimited license to practice medicine and surgery upon completion of a short postgraduate course at the Chicago College of Osteopathy, or at such other school as may be approved for that purpose by the proposed Board of Osteopathic Examiners; and

Whereas, in furtherance of the proceedings pending under the Administration Review Act and the Senate Bills above referred to, it has been charged that the Medical Examining Committee in the Department of Registration and Education has been unfair, arbitrary, and discriminatory in recommending to the Director of the Department of Registration and Education that the said application of the Chicago College of Osteopathy be not approved; and

Whereas, The Council of the Illinois State Medical Society, through the Committee on Medical Service and Public Relations, has made an extensive investigation concerning the action of the Medical Examining Committee referred to, and has held a special meeting solely for the purpose of considering these matters; and

Whereas, The Council is of the opinion that the action of the Medical Examining Committee in recommending disapproval of the said application is sustained by the facts, as can be determined by the Superior Court of Cook County upon trial of the pending proceedings for Administrative Review; and

Whereas, The Council is persuaded that, since the facilities, curriculum, and faculty of the Chicago College of Osteopathy are not comparable with

those of the College of Medicine of the University of Illinois or of the other medical schools located in this state, the Chicago College of Osteopathy cannot at this time be approved as a medical school without seriously compromising present day standards of medical education and training; and

Whereas, the enactment of the Senate Bills 267, 268, and 269 could result in the licensing of persons who are insufficiently educated and trained to practice medicine and surgery in Illinois, contrary to the best interests of the public:

Now, Therefore, Be It Resolved, by the Council of the Illinois State Medical Society that:

1. The Council hereby expresses its confidence in the Medical Examining Committee of the Department of Registration and Education, and its approval of the action taken by the Medical Examining Committee with respect to the application of the Chicago College of Osteopathy.

2. The Council hereby records itself as opposed to the enactment of Senate Bills No. 267, 268, and 269;

3. The Council recommends that the Medical Practice Act of this State be amended so that the Medical Examining Committee in the Department of Registration and Education shall hereafter consist of five doctors of medicine, one osteopath and one chiropractor, all duly licensed to practice in this state;

4. The Council hereby offers to establish a special permanent liaison committee to confer and work with representatives of the Illinois Osteopathic Association, to the end that the physical facilities, curriculum, and faculty of the Chicago College of Osteopathy may as quickly as possible be improved to a point where the school can be approved as qualified to teach medicine in all of its branches, in accordance with present standards of medical education;

5. The Council directs that a full report concerning this matter be made by its Chairman to the House of Delegates of the Illinois State Medical Society.

Charles P. Blair, M.D.
Chairman of the Council
Illinois State Medical Society

Adopted at Chicago, Illinois, April 8, 1951

This resolution was duly forwarded to the President of the Illinois Osteopathic Association and a few days later the following reply was received by the Chairman of the Council.

The Illinois Osteopathic Association, Inc.
5200 South Ellis Avenue
Chicago 15, Illinois

Dr. L. A. Browning, President
Unity Building
Bloomington, Illinois

Charles P. Blair, M.D.
Chairman of the Council,
The Illinois State Medical Society,
102 South First Street
Monmouth, Illinois

Dear Dr. Blair:

This will acknowledge receipt of the resolution presented by the Council of the Illinois State Medical Society in regard to the problems which had been under discussion by representatives of the Illinois Osteopathic Association and the Illinois State Medical Society.

It is unfortunate that the investigations of your Council have not been sufficiently thorough to ascertain the facts as outlined in the following paragraphs.

The Chicago College of Osteopathy and its teaching hospital, the Chicago Osteopathic Hospital, were disapproved by the Department of Registration and Education on April 3, 1950 following a cursory and superficial examination by the Medical Examining Committee in October 1949.

On August 10, 1950, at the formal hearing before the Medical Examining Committee, factual evidence was submitted under oath which established that the Medical Examining Committee in the Department of Registration and Education was unfair, arbitary and discriminatory in recommending to the Director of the Department of Registration and Education that the said application of the Chicago College of Osteopathy be not approved. This evidence is a matter of record in the minutes of this hearing.

The Chicago College of Osteopathy meets the generally accepted standards of medical education in the United States in facilities, curriculum and faculty as established by the fact that every approving authority to which application has been made has given full recognition and approval to this college. The one exception is the Medical Examining Committee of Illinois.

The Chicago College of Osteopathy is approved by the Bureau of Professional Education and Colleges, the official approving agency of the American Osteopathic Association. The Chicago College of Osteopathy is a member of the American Council on Education. Its graduates are accepted for commission by the United States Public Health Service and by the Medical Division of United States Veterans Administration and it is approved through the combined degree program by over 100 colleges and universities.

The Chicago College of Osteopathy is approved for the teaching of Medicine and Surgery in all its branches by the State Licensing Boards of the following states: Indiana, New Jersey, New York, Ohio, Wisconsin, Colorado, Connecticut, Delaware, District of Columbia, Kentucky, New Hampshire, Oregon, Rhode Island, South Dakota, Texas, Virginia, Wyoming, Arizona, Florida, Hawaii, Iowa, Maine, Michigan, Missouri, Nevada, New Mexico, Oklahoma, Pennsylvania, Tennessee, Utah, Vermont, Washington, West Virginia, and California. In the foregoing States the intent of the Legislatures was carried out without resort to Judicial Process.

The Illinois Osteopathic Association is of the opinion that the action of the Medical Examining Committee, in recommending disapproval of the said application, is not sustained by the facts. It has never been the intent of lawmaking bodies that laws shall be administered by the Courts. In Illinois repeatedly, however, the discriminatory action of the Medical Examining Committee has made it necessary to resort to Court proceedings to obtain the administration of the Medical Practice Act of 1923.

The recommendation of the Council that "the Medical Practice Act of this State be amended so that the Medical Examining Committee in the Department of Registration and Education shall hereafter consist of five Doctors of Medicine, one Osteopath and one Chiropractor, all duly licensed to practice in this State" is unworkable. The intent of the Legislature in 1923 has been successfully thwarted by the discriminatory Medical Examining Committee for twenty-eight years by their repeated refusal to recognize any Osteopathic institution for the teaching of Medicine and Surgery in all its branches, even though these same institutions have been approved by the State Licensing Agencies of the States listed above. Therefore, one cannot expect fair administration by a committee which for all these years has proven itself to be biased, unfair and discriminatory. Obviously, in order to make operative the intent of the Legislature in 1923, it becomes essential in the interest of Public Health that Senate Bills No. 267-268-269 be passed in this session of the General Assembly.

The Illinois Osteopathic Association is willing to appoint a special committee to discuss with the Illinois State Medical Society any problems in the public interest.

Very truly yours,
THE ILLINOIS OSTEOPATHIC ASSOCIATION
By L. A. Browning, D. O.
President

This letter very clearly states their attitude concerning their requests or demands. It very definitely infers that they are now decided to trust their care "in toto" to the Illinois Legislature. They are, we understand, quite certain of their ability to win all points as set forth in Senate bill #267, 268 and 269.

The meetings that were held with the Osteopathic group, both the informal one and the formal meetings which were held by the Committee on Medical Service and Public Relations, were all very friendly affairs. Each of the men of both groups present had talked concerning the propositions as they had been brought up. There was no rancor present and at the conclusions of these sessions no prejudice or malice was apparent.

Following our receipt of their reply to our proposed solution for the present at least, of their problem, it was made evident to more than one of our members that they did not desire any further consideration of the problems. Consequently our present course is the defeat in the legislature at Springfield of their three bills, now in the Senate.

Some three weeks ago the Senate Committee which has these bills in charge held a "hearing" at which several of our members appeared as did also those of the Osteopathic group. At that meeting it was stated by more than one of the members of the Senate committee that the matter involved was perhaps "too heavy" for any committee to undertake to decide upon and consequently it was the action of the committee that the bill would be presented to the floor of the Senate for consideration.

There are many and varied aspects involved in this controversy. I can assure you that the committee which handled this has gone into every possible and even probable ramification that might arise. Your Council has considered this in great detail and has not been biased in any respect concerning the procedures that should be followed by us as medical men.

In line with our decision concerning the number of men on the board, legislation was introduced under Senate bill No. 598, which allows the Osteopaths one member who is licensed in the State of Illinois on the Medical Examining Board of the Department of Registration and Education and one from the Chiropractic group who is licensed in the State of Illinois. We are anxious that this bill shall pass and that the other three introduced by the Osteopathic group shall fail.

Respectfully submitted, CHARLES P. BLAIR, M.D., *Chairman of the Council.*

DR. BLAIR: Mr. Chairman, I would like to introduce the following resolution:

Whereas, the Council of the Illinois State Medical Society has thoroughly studied the problems presented by the Osteopathic Association of Illinois, and

Whereas, the Council has unanimously adopted the following resolution, to wit: (as aforementioned).

Be it resolved, that this House of Delegates approve the resolution and hereby adopt it.

DR. BLAIR: There are one or two other matters that the Council wished brought to your attention and with which the Chairman will proceed. The first is a resolution:

Whereas, the outstanding efforts of the Committee on Scientific Work, headed by Dr. Coye C. Mason as Chairman and Director of Exhibits has produced for the Illinois State Medical Society outstanding example of scientific progress, and the group of scientific exhibits at the 1951 annual meeting of the Illinois State Medical Society represent the best in the field of medical progress and recess,

Be it resolved, that the House of Delegates extend to Dr. Mason and his Committee (Dr. Hugh A. Flack, Dr. Arkell M. Vaughn, Dr. Lawrence W. Peterson, Dr. Dwight E. Clark, and Dr. Leo M. Zimmerman) a vote of commendation and appreciation.

The second matter: As is customary at each annual meeting the dues for the coming year are fixed by the House. It is recommended by the Council in session this noon that the dues remain the same for the present year.

It is recommended by the Council that the dues for members entering military service be remitted from the date of their entry into service.

THE PRESIDENT: This Osteopathic report will be referred to Committee "C", with Dr. Warren Furey as Chairman, as the supplementary report of the Chairman of the Council. The other resolutions will be referred to the Committee on Resolutions of which Dr. Goldberger is the Chairman.

DR. BLAIR: As recommended in my original report, I ask that the House of Delegates authorize the naming of the places for meeting in 1952 and 1953 in this meeting of May, 1951, and that they authorize the Council to fix dates for these two years. It has become very evident to those that are managing the annual meeting that the setting-up of the meeting is very difficult a year in advance and that the hotel facilities in the state are inadequate except in Chicago. Last year the meeting was very expensive. We can meet far cheaper in Chicago, but in order that we may have sufficient time, it has seemed advisable to the Council that we set up two years in advance. This was the recommendation in the Handbook but it was thought wise to bring it to your attention.

REPORTS OF COUNCILORS

FIRST DISTRICT

In this my first year as Councilor for the District, I have tried to visit each of the ten Counties that comprise the District. However, the snow and ice of the winter prevented my attendance at some of the County meetings so that I was not able to visit more than eight County Medical Societies in the course of the year. During the year I had the privilege of presenting five doctors with certificates of membership in the Fifty Year Club. In the late autumn a program was arranged at Freeport by the Postgraduate Committee at which I was privileged to preside. My own County Society, Winnebago, has never previously consented to the formation of the Auxiliary, but I have the pleasure of reporting that they have now gone on record favoring the formation of an Auxiliary and it will no doubt be functioning by mid-summer.

Respectfully submitted, J. S. LUNDHOLM, M.D., *Councilor, First District.*

SECOND DISTRICT

Your Councilor for the Second District has had an interesting and active year. All component county societies will have been visited by the time this report is published. I find a healthy activity in the entire district and a keen awareness of our problems.

I further feel that the lay citizens of our district have been very definitely made aware of our economic problems by direct or indirect methods. To further implement our approach to good public relations a meeting to include the county societies of this district has been scheduled at La Salle for June 21. At that time we will have a team, from the Committee on Public Relations, who will develop this subject and show the members of the district just what they should do to further better public relations with the lay population. Your councilor has attended all the regular Council sessions this year. He has been a member of the Finance, Educational and Journal Committees of the Council. He has had the pleasure of awarding two Fity Year Club certificates.

It is with a deep sense of personal loss that I inform you of the very sudden and tragic death of Dr. J. H. Edgcomb of Ottawa, which occurred on February 12, 1951 as the result of an auto accident. Dr. Edgcomb has been a delegate from La Salle County for a great many years. His loss will be felt keenly in this district. A memorial library in his honor is being established at Ryburn Hospital in Ottawa.

May I express my appreciation to the component societies of this district for the courteous way I have been received at their meetings. It has been a pleasure to have been able to serve as your Councilor during this past year.

Respectfully submitted, JOSEPH T. O'NEILL, *Councilor, Second District.*

THIRD DISTRICT

The Chicago Medical Society at the opening of its second century has continued to develop new activities and to strengthen programs initiated in former years. It is mindful of its responsibility to the Citizens of Cook County and its obligations to the profession. It has actively participated in many important civic organizations in the promotion of good health for the people. Its fifteen branches and twenty affiliated societies have taken an interest in cooperating with lay groups within their boundaries or in their particular special fields. The branch societies and the specialty groups as well as the Central Society, known as the Chicago Medical Society, have held monthly scientific meetings with outstanding speakers from all over the country. These programs have brought the best in medical science and progress to the physicians of Cook County.

The Society expects to move about May 1, 1951 into space in the John Crerar Library Building, 86 East Randolph Street. Space for the Society will be on the 9th floor facing Michigan Avenue and Randolph Street. About 60 per cent more space will be available compared to the present quarters. More important probably than the new location is the fact that the Trustees of the Chicago Medical Society at the January 16, 1951 meeting voted a contribution of $2,500 to John Crerar Library. Many doctors in Chicago have felt that we should make greater financial contributions to scientific efforts. Since the Library has for many years maintained its reputation of providing library facilities to medical students and research problems, it is fitting that we should give our funds to support the library. We hope that this can be continued as an Annual Contributing Membership.

NIGHT CALLS—During the early part of 1951, the Chicago Medical Society established a Telephone Secretarial Service. This activity will assure medical service in the home for those unfortunate to need medical care at night and who may be unable to contact their own family doctor, or those who may not even have a doctor. This is probably one of the most important new functions embarked upon by the Society. The problem of night calls has been a serious question

in all communities, particularly in our large metropolitan areas. The Committee on Night Calls has made a study of the services given in other cities and hopes that it may be able to improve upon them in plans for Chicago.

GRIEVANCE COMMITTEE—The medical profession is showing increasing awareness of the importance of Grievance Committees in public relations. National publicity has been given lately to instances where such committees have been organized, but the Chicago Medical Society has had an active Grievance Committee for many years without much being said about it. About twenty complaints a month are carefully reviewed. The physician in question is contacted by letter, telephone, or personal interview. In some instances, hearings are held with both the complainant and physician being present. When the rare indication is met, the case is referred to the Committee on Informal Charges. Little can be done about complaints from "cranks" and psychopathic individuals. But, in most instances, much can and is accomplished through the adjustment of misunderstandings and differences of opinion. Alleged exorbitant fees by specialists especially when the fee has been collected in advance and the result has not been satisfactory to the patient, constitute a difficult problem at times. The complainant is always notified as to the opinion of the Committee. It is believed that this committee performs a valuable function as a liaison between the public and the Chicago Medical Society in connection with complaints and as a medium to improve public relations.

BLOOD BANKS—The Chicago Medical Society is cooperating with the American Red Cross in the collection of blood for the armed forces. The quota assigned to Chicago is 180,000 pints of blood. The agreement between the American Medical Association, the American Hospital Council and other bodies and the Red Cross is that the American Red Cross will undertake no program in the community without the approval of the medical body. The Chicago Medical Society has given the Red Cross approval that they be permitted to proceed with plans to collect this blood in the next year which will be used for military purposes only. The Red Cross is planning to blood group and determine RH on every donor who presents himself for a donation, whether his blood is to be used for whole blood or plasma, and each donor will receive a card concerning this information. The Civilian Defense Committee in Chicago has voted that there is to be an advanced blood grouping and typing program throughout the city.

EMERGENCY MEDICAL SERVICE—The Committee on Emergency Medical Service has been faced with a tremendous task in preparing for casualties that might result from a large catastrophe due to Atomic, Biological or Chemical warfare. In Chicago the Mayor is in charge of Civil Defense in all phases, and the Committee from the Chicago Medical Society is working with the organization which has been developed by Mayor Kennelly and Dr. Bundesen, President of the Board of Health. Chicago hospitals and the fifteen branches of the Chicago Medical Society are cooperating in the over-all picture. Many problems have been faced and progress has been made.

The Committee sponsored an interesting exhibit and showed five Army films, in color and sound, which ran continuously during the Annual Clinical Conference. This exhibit and films served well in the orientation and education of 2,275 viewing physicians as to the magnitude of the problem of Civil Defense, and pointed the way as to how it can be carried out. The complete cooperation of all physicians and ancillary services will be necessary in a continuing manner if the care of the enormous number of casualties is to be achieved.

Planning is on the basis of being prepared for the worst while hoping for the best. Self help by individuals and communities and mutual aid between cities are basic tenets of the plan.

CLINICAL CONFERENCE—The Seventh Annual Clinical Conference was held at the Palmer House, March 6, 7, 8, 9, 1951 with a total registration of 5,272 of whom 3,141 were physicians. There were present 543 representatives of allied professions (nurses, technicians, pharmacists, etc.), 69 scientific exhibitors, 695 technical exhibitors and 824 guests which included senior medical students. Twenty-nine states and six foreign countries were represented.

The program was outstanding and the guest speakers appeared before capacity audiences. In addition to the excellent scientific exhibits and hundreds of technical exhibits, arrangements were made for demonstration periods conducted by members of the Society. These demonstrations, a new feature of the 1951 Conference, proved very popular and during some periods not even standing room was available. The Committee responsible for planning this Clinical Conference deserves a great amount of praise. The yearly increasing attendance indicates that the Clinical Conference is taking its place along with the other important medical meetings of the country.

PRESS RELATIONS—A dinner meeting with the press was arranged by the Press Relations Committee in February. The meeting was attended by nine representatives of the press and radio networks. The program was designed to acquaint these science writers with various activities of the Society which are carried on for the good of and for the protection of the public as well as the medical profession. The discussion by members of the Press Relations Committee and by members of the press resulted in a resolution which will be presented at this Annual Meeting of the Illinois State Medical Society. The Chicago Medical Society has found that these yearly meetings with the press representatives are exceedingly worthwhile.

POSTGRADUATE COURSES—The Chicago Medical Society gives two Postgraduate Courses in the fall, each of one week's duration. These courses were started in 1947. They are open to physicians in good standing in their county and provincial medical societies. In the past about 50 per cent of the men taking the courses have come from Illinois. The registration has always been high, but it is hoped that a larger number of physicians from Cook County and the rest of the state will avail themselves of the opportunity to

attend. In the fall of 1950 courses were given in Diseases of the Gastro-Intestinal Tract, Liver and Pancreas and in Diseases of the Heart, Kidneys and Blood Vessels. They were attended by physicians from 23 states and Canada. Twenty men took both courses. Thirty-five of the men had taken previous courses.

This fall of 1951, a course will be given in "Endocrine and Metabolic Disorders" the week of October 15-19 and a course in "Obstetrics and Gynecology" will be offered the week of October 22-26.

A new feature of the 1950 courses was the books containing abstracts of all papers which were available at cost to those attending and which proved exceedingly helpful and popular. Similar booklets will be given those taking the 1951 courses.

SOCIETY PUBLICATIONS—The weekly Bulletin of the Society goes to all members of the Society and to a large exchange list of county societies throughout the country. This publication contains material of primary interest to members of the Chicago Medical Society. It carries most of the papers presented at the Clinical Conferences and many of the papers given at the Postgraduate Courses.

The Proceedings of the Clinical Conferences are published in book form and may be purchased through the Society office. These Proceedings would be a valuable addition to the library of any individual or hospital.

The publication known as "This Week in Chicago Medicine" has continued to be popular with physicians coming to Chicago who wish to take advantage of the many opportunities to visit clinics, see the work done at the various hospitals and medical schools. The publication lists all important events of the week—meetings, lectures, clinics and conferences. The information is classified by days and hours and is a great time saver. The Chicago press has also found it extremely useful. The mailing covers all hospitals of Illinois, the larger hospitals of nearby states, all medical libraries and city medical societies as well as medical schools. This is just one other service which the Chicago Medical Society maintains for the benefit of its members and for physicians from all sections of the world.

CHILD HEALTH COMMITTEE—The Chicago School Health Program is developing steadily. Under the guidance of its newly appointed director, Kenneth S. Nolan, and with the cooperation and advice of the local medical groups, some fundamental policies are being formed: 1. Health problems will be solved largely at the level of the individual school, through a school health council in which a qualified school nurse will be the catalyzer, and in each of which a local physician will play an important advisory role. 2. Sight and hearing screening will continue and expand. It is already showing important practical results. The need of medical consultants in this phase of the program is becoming evident. 3. School health examinations are being revised in the direction of increasing the number of examinations in physicians' offices and gradually eliminating the inadequate examinations as done in the schools. 4. Practical methods of acquainting physicians with the importance of this program, and with their role in it, are being developed. There is a large and growing group of informed and cooperating volunteer organizations pointing out school health needs, and a keen sense of responsiveness to the public demand on the part of school officials. The outlook for the development of an outstanding school health program in Chicago is excellent.

BLUE CROSS—The annual enrollment in the Chicago Medical Society Blue Cross Group is open to the members of the Society every June. About 2,800 members of the Chicago Medical Society have been interested in this service.

BLUE SHIELD—BLUE CROSS PROFESSIONAL RELATIONS—In January, 1950 the Council of the Chicago Medical Society authorized the formation of a committee to act as a liaison agent between the members of the Chicago Medical Society and the Illinois Medical Service (Blue Shield). At a later date the Council adopted a further resolution authorizing this committee to act in a similar capacity with the Blue Cross. This committee is composed of eight members of the Chicago Medical Society representing physicians in general practice and those in various medical specialties. It was appointed by the Chairman of the Council of the Chicago Medical Society.

It is the function of this committee to represent the medical profession, its attitudes and wishes with regard to the Blue Cross and the Blue Shield before the officers of these organizations; and in addition to attempt to express to the medical profession the purposes and functions of the Blue Cross and Blue Shield and to adjust any difficulties which may arise between them.

One of the principal difficulties arising between some members of the medical profession and the Blue Shield have to do with professional fees. From the outset it has been recognized and clearly stated that the schedule of fees paid by the Blue Shield "are not intended to fix the value of the physicians' services" and that "participating physicians are privileged to charge their usual fees for services." The schedule of allowances of the Blue Shield was prepared in cooperation with various committees composed of members of the Chicago Medical Society. It is hoped that members of the medical profession will accept them as payment in full for their services to patients in the lower income brackets. It is obvious that in many instances physicians' fees are rightfully different from those set forth in the schedule of the Blue Shield. The physician is the judge. There have been a number of instances in which patients have complained of the discrepancy between the physician's fees and the amounts paid under their contract by the Blue Shield. These instances of apparent discrepancy are brought to the attention of this committee for its consideration. In the majority of cases the difference is perfectly justifiable and readily understood. Occasionally it has seemed to the committee that the fees charged by certain physicians might be excessive. In such instances the committee has written to the physicians for additional information. In most cases the physicians have adequately explained the reason for the discrepancy. The committee has regarded some physicians' fees as exorbitant. These cases have been re-

ferred to the Grievance Committee of the Chicago Medical Society for further investigation and such action as the circumstances justify.

It seems to the committee and to the Council of the Society that these rare instances of exorbitant fees far in excess of the benefits allowed by the schedule of the Blue Shield bring discredit both upon the medical profession and upon the Illinois Medical Service (Blue Shield) which the Chicago Medical Society created to aid patients in meeting the costs of medical care. It is of the greatest importance to the public and to the profession that the Blue Shield and Blue Cross succeed in their purpose to make the best possible medical and hospital care available to all who need it and that a few members of the medical profession not be permitted to bring discredit upon the profession as a whole without some definite action by their medical society. It is in the hopes of correcting injustices of this sort and of explaining the purposes of the Blue Cross and Blue Shield to the medical profession that this committee has been organized and continues to function.

ILLINOIS DIVISION, AMERICAN CANCER SOCIETY—The Illinois Division, American Cancer Society, Inc., and the Chicago Medical Society have cooperated in a number of programs during the year. The mission of the Division under the guidance and supervision of physicians, continues to be to assist the practicing physician in every ethical way to reduce the morbidity and mortality from cancer. The American Cancer Society continued support of cancer research projects within the city in the amount of $315,460.00. Financial assistance was provided for several cancer clinics, which included the support of the "pilot" Home Care Plan for Cancer Patients at Michael Reese Hospital.

The Division attempts in every practical way to bring to the practicing physician the latest information concerning improved methods of diagnosis and treatment. Two cancer refresher courses, each lasting five days, are sponsored by the Division with the cooperation of the Chicago Medical Society. The Division distributed, free of charge, to all Chicago physicians desiring it, a professional publication "The Cancer Bulletin," a startling development in medical reporting containing the latest professional information. A film "What is Cancer?" has been shown to many schools of nursing throughout the city. A new booklet, "A Cancer Source Book for Nurses", is being distributed free to nurses applying for it and a new cancer bulletin, "CA, a Bulletin of Cancer Progress", is now being published by the American Cancer Society which will be distributed free to physicians desiring it. Free cancer dressings are available for any home cancer patient upon the recommendation of any Chicago physician. Articles of sick room equipment, including hospital beds, may also be obtained through a gift and loan closet for the home care of the cancer patient.

TUBERCULOSIS CONTROL—The Tuberculosis hospital in the Medical Center in Chicago, voted to be built by the state legislature, is almost completely structurally erected and it is hoped that patients may be sent to this institution of 483 beds by January 1, 1952. The state legislature appropriated one million dollars to improve and increase the facilities in already existing sanatoria and this has done a great deal to improve the physical plants of such institutions as the Municipal Tuberculosis Sanitarium of Oak Forest, the Rockford Sanatorium and others. The Council of the Chicago Medical Society has approved with great enthusiasm the work of the committee to get more beds and to improve diagnostic and follow-up clinic facilities for tuberculosis patients. On October 1, 1949 the Suburban Cook County Tuberculosis Sanitarium District, serving Cook County area outside of Chicago, began operations. Dr. Jerome R. Head, President of the Suburban Board, has mapped out a very progressive program for participation of physicians and hospitals in an all out eradication program. The patients of the Suburban Cook County area are hospitalized in ten sanatoria in the metropolitan area.

Every hospital in Suburban Cook County has been offered a photo-roentgen unit for the x-raying of all admissions into the hospital as well as the hospital staff. The Sanitarium District pays the hospital one dollar for every admission film taken. Weekly clinics are held in more of the suburban hospitals and consultation is available to family physicians at any time. All suburban hospitals are utilized for taking x-ray films on contacts or suspect cases.

The committee is supporting the current appropriation bill of the Illinois Department of Public Health for $9,402,196.00 for tuberculosis control. With increased funds for the Municipal Tuberculosis Sanitarium it is hoped that almost 1,000 more patients can be hospitalized in Chicago within the next year. It is anticipated that 450 patients at the new Chicago State Tuberculosis Hospital will be residents of Chicago and that the Oak Forest Tuberculosis Hospital, the North Riverside Branch of the M. T. will have additional beds, and that other beds in the Chicago area may be available for tuberculosis care. All of these additional beds will require additional funds both at the state and local levels. The Council of the Chicago Medical Society has approved this program. It has also approved in principle a central retake center where any individual may be sent for necessary follow-up once a suspicious x-ray film is found.

A bronchoscopic chest diagnosis center has been established at Cook County Hospital, there has been tremendous improvement in the medical, nursing and hospital care of patients at the Municipal Tuberculosis Sanitarium, Oak Forest Tuberculosis Hospital, Cook County Hospital and the Suburban Cook County Tuberculosis Sanitarium District program has taken place. It is hoped that medical superintendents of all tuberculosis institutions may be placed under tenure and have a civil service status.

The work of this committee has been hard and slow for a number of years but the ripening fruit which can be seen will do a great deal not only to save human life but prevent chronic debility.

THE WOMAN'S AUXILIARY—The Woman's Auxiliary has worked to further the interests of the Chicago Medical Society and at its request gave a

Public Relations Luncheon on October 24th. "Medicine in Public Affairs" was the title of the program with Mr. Everett Dirksen, Dr. Warren W. Furey, and Mr. John Neal speaking and Dr. Morris Fishbein moderating. Every available facility of the Auxiliary, the Chicago Medical Society, the Illinois State Medical Society and the American Medical Association was studied and employed if possible in the production of this meeting. Over seven hundred persons, including physicians' wives and representatives of several hundred leading civic organizations attended as guests of the Auxiliary, its branches or its individual members. The meeting received local and national press coverage.

A second public relations program, "Chicago's Civil Atomic Defense Plan" was presented on November 14 and this was the first program on the current Civil Defense Plan put on by a woman's organization in Chicago. Each guest was provided with a copy of the U. S Government pamphlet "Survival Under Atomic Attack." A third program on February 13th, 1951 presented "Chicago's School Health Program" with Dr. John L. Reichert as moderator in audience participation. The meeting was attended by over three hundred persons and was considered successful in every way as it brought together school principals, presidents and health chairmen of Parent-Teacher Associations, and persons and organizations on the roster of the Public Relations Committee of the Auxiliary.

On April 10th the Auxiliary, after weeks of work, brought together a group of more than five hundred at a Nurse Recruitment program and tea. The Auxiliary may prove to be the important factor in securing the interest of young men and women in entering the nursing profession. It also sponsored an essay contest on "Why I Want To Become A Nurse" which has created wide interest.

The results of the year's work already apparent are most gratifying. The ample subsidy granted to the Auxiliary by the Chicago Medical Society for the purpose of Public Relations made it possible to carry out this extensive program in complete detail and with just dignity.

COMMITTEE ON MEDICAL SERVICE—The Committee on Medical Service had an active and successful year. The general purposes of the Committee are three in number: 1. The physician is to be educated and kept abreast of the current social trends and their relation to the medical profession; 2. The laity is to be educated in reference to the tax expense and other effects of legislation promoting the socialization of medicine or other activities which might interfere with competent medical services; 3. The Educational Campaign of the American Medical Association is to be stressed to both the physician and the public.

OTHER COMMITTEES—Many other committees of the Chicago Medical Society have carried on active programs relating to maternal welfare, nursing problems, industrial health, prepayment medical plans, medical care of the indigent and recipients of unemployment relief. There has been active participation in cooperative programs with the Board of Education, the American Diabetic Association, the Board of Health, the Welfare Council of Metropolitan Chicago and the Chicago Hospital Council.

Respectfully submitted, WADE C. HARKER, M. D., OSCAR HAWKINSON, M.D., J. L. REICHERT, M. D., F. LEE STONE. M. D , LEO P. A. SWEENEY, M. D., ARKELL M. VAUGHN, M. D.,*Councilor, Third District.*

FOURTH DISTRICT

Your Councilor for the Fourth District makes this report to you at this time, with much more satisfaction than at any time previously. This satisfaction arises from the fact that during the past year the amount of work and details in the Fourth District has been considerably greater. The component Societies have entered into the problems of economics as well as those of science; and the effect has been very gratifying. The Fourth District is in our opinion, in very good condition, both professionally, economically and in the Public Relations aspect of the profession to the population of our geographical area.

All of the component Societies in this District have been more active in their meetings and their attendance has been better than for several years past. By far the greater majority of the members in this District have stepped out of their ivory tower and have been energetic in their activities as citizens. This awakening from complacency is indeed very pleasing. It is to be hoped that this will continue; and that in the same vein or category the physicians will acquaint themselves with what organized medicine really is, how it actually works, and what their particular status is in the whole scheme.

In addition to the regular County meetings which have been held in each of the component societies during the past year, several other meetings of a professional nature have been held. For the most part these have all been well attended. In most of the Counties any organization, that has a program dealing in any way with health, has been contacted in order that a physician may appear as a member of the directing body of the organization and especially when any health subject is discussed in any forum.

During the past year three new hospitals have been opened in the District; one at Aledo, Mercer County, one at Carthage in Hancock County, and in Galesburg, the "State" has opened a Research Hospital for the study of certain types of Psychiatrics. This is established in the buildings built and occupied in World War II, and which was known as Mayo General Hospital. The facilities of these first two institutions have indeed quickened the tempo scientific medicine in their localities and the

Research Hospital will add greatly to the potentiality of the Knox County organization.

No problem of particular importance or of definite policy, in this district has been brought to the attention of the Councilor. Effort has been made to increase the number of Auxiliary organizations and emphasis has been placed on the public relations problem that may be met by a grievance committee locally, as well as the one that is already functioning at the State level.

Your Councilor has continued to take a very active part in the Council work this year as its Chairman, and in the work of the various committees. A record of this activity will be found in the reports herewith printed in this handbook.

Your Councilor is very grateful for the hearty cooperation that has been accorded him by all the component societies, their officers, and their individual members. It is his desire to express appreciation and pleasure to act as the representative of the Fourth District.

Respectfully submitted, CHARLES P. BLAIR, M. D., *Councilor, Fourth District.*

FIFTH DISTRICT

The past year has been an important one for the medical profession in both the State and the Nation. The educational campaigns which the American Medical Association and the State Society have been conducting are bearing fruit. Physicians are awakening to the fact that personal work among their patients and friends is paying good dividends. On every hand there is evidence that the business interests of the country are sympathetic to the medical profession. It is true that we have in the United States the best medical service of any country in the world and the profession is giving much time and effort to convince the public of this fact.

We believe the plan of the Committee on Medical Service and Public Relations to hold meetings in each councilor district is very good. The profession is beginning to realize how important good public relations can be. Every encouragement should be given physicians, especially the young men, to engage in community affairs.

The elections last fall have given proof that the people of this country are not in favor of government controlled medical service. The rapid growth of voluntary health insurance and hospitalization plans are evidence that the public is realizing the necessity of including something in the family budget for medical services.

In the Fifth District the county societies except in the smaller counties have held regular meetings with average attendance. Two postgraduate conferences were held in the district. One in Bloomington in October and one in Pekin in November. It has been difficult to arrange suitable dates for these meetings without conflicting with other medical meetings. The opinion prevails that there are too many medical meetings and physicians can not attend all of them. The American College of Surgeons demands that the staff of all approved hospitals must attend regularly all staff meetings and this tends to cut the attendance at county society meetings. Physicians who are members of the Academy of General Practice are holding regular meetings which sometimes conflict with county meetings.

There has been some opposition to the increase of dues, especially the dues of the American Medical Association. There is no shortage of physicians in the district; in fact there are more physicians in practice now than before World War II. A very few of the younger men have been called into military service.

Dr. W. R. Marshall of Clinton has retired as secretary of the DeWitt County society. He has served faithfully for many years and has been very helpful throughout his long period of service. We regret that he has felt it necessary to retire as secretary of that county.

Respectfully submitted, RALPH P. PEAIRS, M.D., *Councilor, Fifth District.*

SIXTH DISTRICT

Another year of membership has been a pleasant one for your Councilor. It is hoped that it has been of some benefit to the constituent societies. Local personal situations have made it impossible for him to make as many visits to County Societies as he had hoped. Nevertheless by correspondence, telephone communications, and personal contact he has endeavored to keep in touch with them.

The Councilor year started off as usual with the pleasant picnic of the Jersey-Greene County Societies. The outstanding event of the year was the Adams County Centennial which is reported by hearsay only, as your Councilor was in another part of the country at another medical meeting at that time. October and April are certainly open seasons on medical meetings. "The first hundred years are the hardest," yet Adams County goes right ahead as always with plans for a big Public Relations meeting May 14, the week before the Annual Meeting. More power to such an interested group in organized medicine! Our Past President, Dr. Walter Stevenson, has continued to be a tower of strength in the curricular and extra-curricular activities of this area. Your Councilor is a babe in arms compared to his force and strength.

Inconsistent as it may seem with the chairmanship of the Post-graduate Education Committee in this District, no conferences were held here this year. Fortunately, however, two counties are vieing for this privilege during the year to come. Morgan County has one of the projects furthered for the Civil Defense Program coming up on April 12 (two days after the deadline for this report). Macoupin County had a special meeting for Dr. Otto Hauser of Mt. Olive, March 27, at which Dr. Hauser became a member of the Fifty Year Club. Morgan County had a joint meeting of

physicians, dentists, attorneys, law enforcement officials and pharmacists March 29.

The chief headache during the year has been the hospital situation in Staunton, Macoupin County. Reports in the St. Louis Post-Dispatch caused considerable concern to that society, your Councilor and the area involved. Thanks to the recommendations and advice of the Council Committee on Public Relations and to a personal visit by Mr. James Leary, Public Relations Counsel of the State Society, plans are under way for an active presentation of the stand of organized medicine on this problem.

As always during his membership on this Council the professional and personal associations, and friendships have meant much to the representative from this area. There is still unfinished business. It is hoped that more may be accomplished in the future.

Respectfully submitted, F. GARM NORBURY, M.D., *Councilor, Sixth District.*

SEVENTH DISTRICT

It is our pleasure at this time to report that the component societies of this district are in very good shape. They are active, have regular meetings and their officers are most cooperative. There has been a considerable increase of physicians in the rural areas as well as the urban centers in the district; very few of our communities lack physicians.

Your Councilor has attended most all of the meetings of the Illinois State Medical Society Council and committee meetings of the Scientific Service and Postgraduate Committees. The Postgraduate Conference held in each district has been well attended, showing the interest taken in the work of the Postgraduate Education Committee.

The outstanding activity in the district in the past year was the Postgraduate Conference held in Effingham, December, 1950. There was an excellent program presented. The speakers were outstanding and well received by an enthusiastic audience of above average and all who attended were well repaid for the time spent in attending. The Effingham County Society was a perfect host and entertained royally.

In some areas of the district there is need for more hospital beds which could be used by any licensed physician to care for his patients. There are only so far this year, Effingham and Shelbyville, which seem to be starting to build to give them the extra beds needed.

Many practitioners in the district have received and will receive their Fifty Year Club certificates and emblems. Your Councilor has attempted to attend meetings of most of the county societies. There seems to be some unrest as to when those in the medical reserve priority 1, 2, and 3 may be called into the service.

Your Councilor expresses his thanks to the officers of the county societies in their support and cooperation, the past year, and hopes they and the entire membership will continue their interest in the scientific and the economic sides of medicine.

Respectfully submitted, C. H. HULICK, M. D., *Councilor, Seventh District.*

EIGHTH DISTRICT

Medical affairs and activities in the Eighth Councilor District of the State of Illinois during the past year have gone forward without too much difficulty. The ranks of those physicians taken by retirement or death have been filled by young well-trained men in virtually all instances. With the exception of approximately three counties, the physician-patient ratio has been satisfactory for the needs of the communities and for the work load per physician. Those counties that are short on medical personnel have young men in medical schools now under contract to return to their areas of need for practice.

Since the last annual meetings, a number of new hospital beds have been placed in use in Lawrence County and in Champaign County. The opening of these facilities has increased the availability of hospital care to the citizenry.

Some of the expected problems have arisen in connection with the Public Aid Commission's medical activities, as well as the United Mine Workers' Health and Welfare Fund. Virtually all these problems have been solved in an agreeable fashion, and no court action has been taken on any problem cases.

At the time this report was submitted, preparations were in order for the annual Postgraduate Conference to be held in Champaign on April 12. It is the opinion of this Councilor that the Postgraduate efforts had best be oriented along the lines of the Indiana telephonic system instead of the transportation of so much able personnel to so many spots in the state. Others may violently disagree with this view but the cost factor needs to be seriously considered in appraising this Postgraduate endeavor.

During this past year, a Woman's Auxiliary was established in Champaign County, and the enthusiasm with which this Auxiliary is working is certainly an example to any county that desires to establish one.

To the numerous county officers who have been so helpful in the solution of many problems, I want to extend my sincerest thanks.

Respectfully submitted, HARLAN ENGLISH, M. D., *Councilor, Eighth District.*

NINTH DISTRICT

In sending in my report for the current year, I am glad to say that conditions in District 9 are running along smoothly. There have been several good meetings, among them the Postgraduate Meeting in Carbondale on April 5. A fine scientific program, with a good attendance, this was a union meeting of the 9th and 10th Councilor Districts.

I think it will be well to have more meetings of this kind in the future.

Our annual meeting of the Southern Illinois Medical Association met in Belleville in November. There was a large attendance and good fellowship prevailed. The meeting was highlighted in the evening by a lecture from Dr. A. C. Ivy on Medicine and Religion. There were several other meetings also during the year—two of the seven county organizations with outstanding interest and attendance.

The Welfare program of the United Mine Workers of America as administered at present seems to meet with hearty approval by the miners as a whole. This is a very fine thing and I believe other organizations would do well to establish similar programs.

There is some complaint in this district, as in the past, concerning the I. P. A. C. program. The principal complaint is that of low fees and the indirect payment of their bills. I believe we are to have some relief soon on both complaints.

Throughout the district the shortage of hospital beds and nursing service is still a serious problem. However, there is some relief in sight with a few new hospitals opened during the past year and others are to be dedicated in the near future, one at Mt. Carmel and one at Mount Vernon. The State T. B. Sanitarium at Mount Vernon also is to be dedicated on Sunday, May 13. Plans are also well under way for the construction of a new hospital at Marion.

Several men in this district completed their fiftieth year in the practice of medicine and were awarded their fifty year certificates.

All physicians willing to work have been very busy. There are some two or three areas where additional medical personnel is needed.

It has been a great pleasure to be your councilor during the past year.

Respectfully submitted, CHARLES O. LANE, M. D., *Councilor, Ninth District.*

TENTH DISTRICT

During the past year two new hospitals have been completed, one in Anna, and the other in Red Bud. They are considered the last word in hospital construction and will answer a very urgent need for hospitalization for the people in their districts. The State Department of Public Welfare is building additions to their present institution at Anna and also remodeling some of the older buildings, which will be a great improvement in the care of their patients.

There have been a number of component society meetings with excellent programs. The Southern Illinois Medical Association met in Belleville, at the St. Clair Country Club last November for an all-day session and it was very well attended by men from all over Southern Illinois. It was one of the outstanding meetings in this district for the year.

The Belleville Chapter of the American Academy of General Practice had a number of their school meetings which have been very well attended and the physicians report having had very excellent instruction.

The Postgraduate Conference of the Illinois State Medical Society, a joint meeting of the Ninth and Tenth Councilor Districts, was held at the Eagles Home at Carbondale, April 5th. Unfortunately, the date conflicted with that of the American Academy of General Practice School of Instruction and an important county medical meeting and for these reasons was not well attended. Financially, it was a success—that is, there was not a deficit. As a suggestion, in the future it might be advisable to check with the counties participating in order to avoid selecting a date for the conference that might conflict with other medical meetings.

Due to the fact that I have served the Tenth District as Councilor for a number of years, I feel it is time to have new and younger blood to carry on and, therefore, called a meeting of the delegates from the component County Societies of the Tenth District to select their representative to take my place so that there would be no misunderstanding at the annual meeting.

Let me repeat what I said in last year's report: "This is an election year. Don't place politics above what is best for yourselves and the public." I think the doctors as a whole did a very excellent job, but let me say that we must carry on with our educational campaign pertaining to the social welfare state.

As this will be my last Councilor report, I wish to express my appreciation to all the officers and members of our state and county medical societies, not only of the Tenth District but the state as a whole. I have made a number of acquaintances and friends of physicians throughout the state and after all is said and done, it is friends that make life worthwhile.

Respectfully submitted, G. C. OTRICH, M. D., *Councilor, Tenth District.*

ELEVENTH DISTRICT

All component county societies in this district continue to be in fine condition. They have regular meetings with good programs and enthusiastic members. In all counties except one, meetings are held monthly, except during the summer and attendance is reported to be good.

The annual Postgraduate Conference was held in DuPage County this year for the first time. The program was excellent and the attendance was fair. As suggested in this report last year, it is the opinion of your Councilor that we should make a careful appraisal of the number of medical meetings being held in each and every county to determine whether or not there is a multiplicity of meetings and whether all should be continued.

No problems of major importance have arisen in the district. There is still criticism of the profession in regard to night calls and fees. These are important problems for the county organization to solve and they can be solved if effort and cooperation can be obtained.

During the past year, your Councilor has continued to take a most active part in the Committee work of the Society. This in addition to his duties as Trustee of the American Medical Association, and Chairman of the Medical Examining Board of the Department of Registration and Education of the State of Illinois, has necessitated his being away from home about one-half of the time the past year. Fortunately, his local colleagues have appreciated the call on his time and have been very cooperative in assisting in the care of his patients when he is absent.

Your Councilor wishes to thank the officers of the County Society for their cooperation, the past year. They, too, have been most considerate in their request for attendance at their meetings. He wishes to thank the Secretary of the Illinois State Society and those in his office for their cooperation.

Respectfully submitted, E. S. HAMILTON, M. D., *Councilor, Eleventh District.*

REPORTS OF COUNCILORS-AT-LARGE

My period of service of twenty-six years as a member of the House of Delegates and the Council of the Illinois State Medical Society terminates with this annual meeting. Only one familiar face remains in the Council that was present in 1925 when I became Councilor of the Seventh Councilor District, namely, Doctor Harold M. Camp, Secretary of this Society. It has been indeed a great pleasure and privilege to have served through the years with so fine a group of men, many of whom have passed to "where beyond these voices there is peace." For all the honors the Society has conferred upon me, I am deeply grateful. While my duties as a Councilor, President-Elect, and President, and Councilor-at-Large, have required a sacrifice of time, energy and produced many *heartaches* or shall I say many *headaches,* let me again assure you that I have received far more from this Society than I will ever be able to repay.

During this last year a large percent of physicians took an active part, regardless of political affiliation, in the activities necessary to bring victory to the cause of organized medicine. The public, too, has been alerted as never before to the dangers inherent in doctors, hospitals, and medical care, under Government control. Looking ahead in a world of confusion, tension and a possible third war, shall medical care be rationed? The discriminatory drafting of the medical profession, which has given this country the highest and best medical care of any country in the world, seems to me to be preposterous. The challenge of the medical profession in this crisis will be met but we cannot afford the lavish call-up of medical talent which prevailed in 1942. There is the threat of atomic, germ and biological warfare which means that we need an adequate supply of doctors on the home front to fill the needs of civilians. Already overworked doctors must fill military and civilian needs. The hospitals also face the problem of caring for civilians with a shortage of personnel. The military forces should be asked to lower demands wherever there is a possibility.

We are not yet at war—we may never be at war —or—it may come tomorrow. We are told "we are not arming because war is inevitable; we are arming because the facts of life in the world about us have clearly shown that military weakness is an invitation to war. Until the society of nations produces a vaccine for the plague of war we have no recourse but to use the preventative measures of military strength." The Atomic Age has brought us to a new problem as voiced by Doctor Richard Meiling recently when he said, "When a nation is attacked with modern weapons the whole nation is in the midst of war."

We now have to face this problem with too few doctors and too many places for them. This can only be acomplished by rationing medical manpower to fill military, hospital and civilian needs, by carefully selecting who is to go and who is essential at home, by placing military personnel strategically, by coordinating hospital staffs and by unifying the Armed Forces.

"With malice toward none" and with an abiding confidence in the future of organized medicine in general and the Illinois State Medical Society in particular, will say adios. May God bless you everyone.

Respectfully submitted, I. H. NEECE, M. D., *Councilor-at-Large.*

Your Councilor-at-Large has nothing of importance to report except to state he has never known so much cooperation and sincere society fraternalism as prevails in the State Society.

It has been a privilege and an honor to serve you.

Respectfully submitted, WALTER STEVENSON, M. D., *Councilor-at-Large.*

REPORT OF THE EDITORS

During the past year, no changes have been made in the external appearance of the *Journal.* The Editorial Board and the Journal Committee are contemplating a change and although several sample covers have been presented none have met with their approval.

With the passing of Dr. John S. Coulter, the section on Physical Medicine Abstracts lost an able and trustworthy editor. The loss will be keenly felt not only in Illinois but throughout the nation. Meanwhile, we have been most fortunate in having Dr. Emil D. Hauser assume the responsibility for preparing the physical medicine abstracts. We have endeavored to increase the number of scientific editorials during the past year. These have included some timely topics as sympathectomy, arteriosclerosis, cholesterol, histoplasmosis, acute pancreatitis, Vitamin B_{12}, the anti-coagulants and

ACTH and cortisone. In addition, several articles have been submitted by guests on subjects of interest to all physicians in Illinois. Less space has been given to fight against Compulsory Health Insurance and the Society's participation in the national education campaign.

Again we have been most fortunate in receiving many fine original articles for publication. At all times we have had an ample stock pile of material suitable for publication. Unfortunately, many papers are too long and often contain more historical and bibliographical material than is deemed necessary. Now and then we have been forced to return papers to the authors for corrections and shortening. Some of these would require thirty or more typewritten pages which would take up eight or nine pages in our *Journal*. When corrected, the majority resulted in a better paper without losing the salient effects which the authors desire to present. Brevity is stressed because it is our desire to publish as many papers as possible in each issue of the *Journal*. They usually contain the essentials and are more readable. There are very few subjects which cannot be properly presented in two pages of the *Journal;* furthermore, there is a paper shortage which is becoming more acute as the months pass by.

The Editorial Board and the Journal Committee are evaluating the advertising contracts more critically than ever before. New accounts are being accepted whereas those which seemed questionable have been eliminated.

Your editors again desire to thank the Editorial Board and the Journal Committee for their assistance and encouragement. A small executive group has been selected from these committees which has met on short notices in Chicago on several occasions for luncheon. Much has been accomplished for which we are grateful. These committees deserve a vote of thanks for their devotion and work in the Society. We also desire to pay our respects to Mr. L. E. Malley, who, as business manager, has worked diligently, carrying on the many details in his official duties.

This is your *Journal* and we welcome your criticisms and recommendations. We will give them prompt and serious consideration.

Respectfully submitted, HAROLD M. CAMP, M.D., *Editor.* THEODORE R. VAN DELLEN, M. D., *Associate Editor.*

REPORT OF THE EDITORIAL BOARD AND JOURNAL COMMITTEE

This Board, having a considerable membership, meets but once a year. During the interim it functions by consultation of various of its members, as occasion demands, with the editors. At its last meeting, October 12, 1950, the chairman was directed to ask the Council for permission to assemble a few of its members at luncheon meetings from time to time to discuss various matters pertaining to the Journal. The Council granted this request. The first meeting of this small group occurred January 16, 1951.

At the October meeting the Board expressed the opinion that the cover page of the Journal should be uniform instead of changing from time to time as it does at present. This is still under study. Various samples will be presented to the Board for further action and recommendation to the Council.

There was considerable discussion as to the type of papers to be published in the Journal. This related particularly to papers and talks dealing with the various specialties. It was the consensus of the Board that the Journal should publish only such special papers as would have wide interest among men engaged in the general field of medicine and surgery. It was also recommended to the Council that speakers before the various sections of the Society should be told in advance that if they wished their papers published in the Journal they should be of a nature that would have a wide appeal. Many excellent papers are presented, but they are of interest exclusively to specialists. It was the opinion of the Board that such papers should be presented to specialty journals rather than to a state journal. It seems that in our society, as in all other state societies, specialists constitute a relatively small percentage of the membership. The Journal must of necessity present material of general interest.

The Board recommended that the Journal activities in Chicago should have the attention of a full time secretary. This matter was re-emphasized at the meeting January 16, 1951.

Attempts have been made to secure articles of an editorial nature either from distinguished members of our own society or from leaders in medicine in other sections of the country. These efforts met with little success.

Members of the Board are constantly striving to improve the quality of the Journal.

Respectfully submitted, JAMES H. HUTTON, M.D., *Chairman.* J. J. MOORE, M.D., EDWIN M. MILLER, M.D., HARRY CULVER, M.D., CHAUNCEY C. MAHER, M.D., FREDERICK H. FALLS, M.D., RAYMOND W. McNEALY, M.D., WALTER STEVENSON, M.D., ARKELL M. VAUGHN, M.D., EDWIN F. HIRSCH, M.D., *Editorial Board.* HARRY M. HEDGE, M.D., *Chairman.* CHARLES O. LANE, M.D., JOSEPH T. O'NEILL, M.D., LEO P. A. SWEENEY, M.D., F. GARM NORBURY, M.D., R. C. OLDFIELD, M.D., *Secretary, Journal Committee.*

REPORTS OF STANDING COMMITTEES

COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

The Committee on Medical Service and Public Relations has held five meetings during the year ended April 1, 1951. Its work, consisting of the supervision of the legislative representation and the public relations of the Society, is going well in general and the Society is carrying out its responsibility to the public and the profession and bearing its share of medicine's national fight to protect its freedom.

Public Relations. The public relations phase of the committee's work, meaning its contacts with outside groups except for lay health education, and in charge of James C. Leary, director of public relations, is undergoing a major reorganization as this report is written.

For the last two years, that major part of it, which is concerned with the fight against socialization, has to a large extent centered around the work of the Speakers' Bureau. That followed the general lines laid down by the American Medical Association through Whitaker and Baxter. We have placed in the last year some 350 speakers. We distributed more than 10,000 pieces of literature. We supplied our speakers with the still-effective speakers' cards, developed more than two years ago. And we have cooperated with dozens of other organizations interested in the campaign, along the lines outlined in our reports for 1949 and 1950.

However, as we approached 1951 and met to evaluate our program, it was obvious that it needed re-formulation. The sinister influences working against us have changed their strategy from one of seeking complete socialization by a single piece of legislation to one of piecemeal socialization by a series of small steps. Though some of our adversaries had been rejected by the voters, it was evident that our fight before Congress was far from won and that we must expand our forces and establish a much broader base for the continuation of the campaign.

After considerable discussion, it was decided to attempt to stimulate a greater participation by both county societies and individual memberships. Letters were sent to all society secretaries sugggesting that each set aside one of its monthly meetings for a discussion of public relations, for which we would supply speakers. Since there are 92 county societies it was also suggested that the various societies set up joint meetings wherever possible.

The response as of the date of this report, April 1, has been satisfactory. Within a month the Macon County Society set up a meeting at Decatur with several adjoining counties represented. A dozen more are now scheduled, though most of them are to be held next autumn because of the number of postgraduate conferences scheduled for April and the imminence of the annual state meeting in May. Most societies, too, do not meet in the summer.

The procedure envisioned by your committee for these meetings is to present three speakers, Dr. Camp discussing the importance of medical unity through professional organization, Mr. Leary outlining suggested procedures in public relations and Mr. Neal speaking on voluntary prepayment insurance.

The object is multiple—to sell the value of the state society and its services, to weld the medical profession and its allies into a more effective political unity, to encourage local activity, to outline programs for local execution, to suggest that the county medical societies use their community and political power for the benefit of the community, their patients and their profession, and to stimulate continued and expanded participation in political action committees outside medical organization.

At the same time, the Speakers' Bureau is to be strengthened. The list of speakers is being studied and inactive listings removed. Additional speakers should be recruited. Speakers' material should be reworked as the pattern of legislative proposals changes. This material should be expanded to take in various state issues in addition to the national sickness insurance issue.

Carrying out this program will be a most important purpose of the committee during the next year.

Political Activities. Throughout most of last year, we took an active role in urging medical participation in political activities, such as intensive efforts to see that all physicians, their families and friends were registered and actually voted. All this activity, of course, was carefully cleared with our legal counsel to make certain that it was within bounds set by law for organizations such as ours. It was also maintained on a strictly non-partisan basis. At the same time, we observed with considerable interest the operations of the Interprofessional Committee of Physicians, Dentists and Pharmacists in Cook County and the Illinois Healing Arts Committee in the remainder of Illinois. These were non-partisan groups of individual members of the three professions engaged in screening and supporting candidates for office on the basis of their attitudes toward the socialization of medicine. From their operations, however, your committee remained strictly aloof and the only reason for mentioning them here is to make certain that it is entirely clear to all that the Society as such had no part in their programs.

LEGISLATIVE. The legislative phases of the committee's work are coordinated by John W. Neal, general counsel for the Society and executive secretary of this committee. The committee notes that the 67th Session of the General Assembly of Illinois is now in session and will not finally rise until June 30.

Of the 1,292 bills thus far introduced, relatively few are of direct significance to the medical profession. However, the session will be a crucial one because of the efforts which are being made to weaken the Medical Practice Act by creating separate examining and regulating boards for osteopaths and chiropractors.

The chiropractic bill (S. B. 141) is a perennial. A similar bill has been introduced at almost every session of the legislature since the Medical Practice Act was adopted in 1923. The bill is sponsored by a group of unlicensed chiropractors who do not have the educational requirements prescribed by the Medical Practice Act, but who are determined to change the law rather than comply with it.

Although the bill is ostensibly for the purpose of setting up a separate board of chiropractic examiners and prescribing educational standards, its real purpose is to be found in the "grandfather clause" which would enable most of these unlicensed and poorly qualified chiropractors to obtain a license without examination.

The sponsoring group is carrying on an extensive, strenuous and expensive campaign in favor of the bill. The measure is being opposed not only by this Society, but also by the state organization of the licensed chiropractors of Illinois, who have qualified themselves and become licensed under the Medical Practice Act.

Senate Bills 267, 268 and 269 are sponsored by the osteopaths of Illinois. The bills would create a separate board of osteopathic examiners, and would remove

osteopathy completely from the jurisdiction of the Medical Practice Act. They would further authorize osteopaths to engage in the general practice of medicine and surgery without limitation, and without supervision of any kind by doctors of medicine. The board of osteopathic examiners which would be created by S. B. 267 would have complete authority to give examinations, grant and revoke licenses, and examine and approve osteopathic schools for the teaching not only of osteopathy, but of medicine and surgery as well.

This bill also contains a "grandfather clause" which would enable virtually any licensed osteopath, in Illinois or elsewhere, to take the examination to practice medicine and surgery without limitation, upon proof of having had a mere 300 hours of postgraduate training in medicine and surgery in an osteopathic school approved by the osteopathic examining board. These bills are powerfully sponsored and supported. Their enactment would place osteopathy on a common plane with the practice of medicine in this state, and would terminate any supervision of osteopathy on the part of medical men. The osteopathic and chiropractic bills have been disapproved by this committee and by the Council, and every member of the Society has been urged to work diligently for the defeat of these bills.

Another bill of great interest and importance to medical education and scientific research is H. B. 490, the so-called "dog pound" bill. This bill, which is similar to one which was defeated two years ago, is designed to make available to approved medical schools, laboratories, and other teaching and research establishments, a more nearly adequate supply of experimental animals than is now obtainable. The bill would require the keepers of public pounds to turn over to approved educational and research institutions, all stray, impounded, and unclaimed dogs and cats which would otherwise be destroyed. The bill is faced with the hysterical but effective opposition of the Hearst press, the professional antivivisectionists, and a number of well-meaning citizens who have been deceived and taken in by the dishonest propaganda against the bill. Prospects for passage of the bill appear reasonably good at this time, although a hard and bitter fight lies ahead.

Of the other pending bills of medical significance, the following are of particular importance:

S. B. 87 would permit physicians from other states or countries who have either failed, or are not qualified to take, the examination to practice medicine in Illinois, to receive temporary licenses without examination to practice medicine under supervision in the hospitals and institutions operated by the Illinois Department of Public Welfare. The bill would in effect establish two standards of medical care in Illinois: A high standard for those who are not obliged to reside in state institutions, and a much lower standard for those who are so unfortunate as to be wards of the state. Because of the discrimination which would thus result against the inmates of our State hospitals, the Council has felt obliged to disapprove this bill. The Council has endorsed, however, a proposal to increase substantially the salaries of the physicians staffing the state hospitals.

S. B. 396, which was introduced at the request of the Illinois State Medical Society, would re-establish the Bureau of Industrial Hygiene in the Department of Public Health. This bureau has been abolished by executive order upon the recommendation of the Schaefer Commission. Unless this bill is enacted, all industrial hygiene functions will hereafter be supervised by the Illinois Department of Labor, rather than by the Department of Health, where such an activity logically belongs.

Another pending bill would drastically increase the penalties for "peddling" narcotics to minors. Other bills would regulate the practice of practical nursing, raise the ethical standards of the optometric profession, and require state licenses for general hospitals. It is expected that bills will be introduced providing for the continuation of the program of state aid for tuberculosis, the fight for which was successfully led by the medical profession two years ago. It is also hoped that provision will be made for the payment of more adequate fees for medical services by the Illinois Public Aid Commission. Other pending bills would transfer crippled children's services from the University of Illinois to the Department of Public Welfare, and consolidate the Illinois Public Aid Commission into the Welfare Department. Passage of these bills does not appear probable.

H. R. 6000, enacted by the Congress last year, created a program of federal subsidy for financial aid to persons who are totally and permanently disabled. Legislation is pending to implement this program at the state level, and to qualify Illinois to receive federal funds for this purpose. No bill for compulsory health insurance at the state level has been introduced, and none is expected.

On the national scene, it does not appear likely that any serious effort to enact compulsory health insurance will be made in the present Congress, in spite of Federal Security Administrator Ewing's continuing drum-fire of propaganda. A bill for federal aid (subsidy) to medical education is pending, and whether or not its passage can again be averted is not now clear. The Hill-Burton Hospital Survey and Construction program has met with widespread acceptance and support. The appropriation of an additional $75,000,000 to permit its continuation now seems assured.

Conduct of the legislative work has been facilitated, and congestion in the office of the Educational Committee has been relieved, by having the Secretary's office in Monmouth maintain legislative addressing and mailing records and equipment, and handle all large mailings. For smaller mailings, news stories, rush jobs, etc., the facilities of the Public Relations office in Chicago have been utilized extensively.

Other Activities. Aside from these major developments, the year has been a busy one. It is impossible within a reasonable space even to mention all the ramifications of the committee's responsibilities, but we will try briefly to summarize their main phases. Some statistics, though they cannot tell the story, give some impression of the intensity of public relations

activity: Our public relations director, in addition to the five Committee and eight Council meetings and the Annual Meeting, attended 44 meetings of various medical committees directly connected with the Society's work, four A. M. A. meetings, 15 meetings of satellite groups in various medical fields, and 21 connected with the medical phase of civil defense. These do not include individual conferences with members of the committees or officers of the Society in connection with the public relations program. He also made talks before a Business and Professional Women's Club, the Illinois Federation of Women's Clubs, the Rogers Park chapter of Bnai Brith, the Health Improvement Association state meeting at Peoria and several lesser groups.

SPEAKERS' BUREAU. The work of this agency tapered off in November, 1950, but previous to that time had maintained a high level of activity. It is expected that demand for our speakers will begin to pick up again next fall and it is our purpose to outline by that time new approaches to the various phases of the subject to be promulgated through the next two years. In this work, of course, we have continued our cooperation in the operations of Whitaker & Baxter in the American Medical Association's national education campaign and we take this occasion to express our commendation of their masterly handling of that program and their never-failing willingness to cooperate with our efforts.

In last year's report, the Whitaker & Baxter tabulation was quoted as showing a total of 307 resolutions by Illinois organizations against socialized medicine. As of April 1, 1951, that total had risen to 417 and Illinois still stood high in the roster of states contributing these signed, incontrovertible proofs of mounting public support for the campaign against Socialism in our country.

CIVIL DEFENSE. A new issue which has brought new responsibility in the last year is that of the medical phase of Civil Defense, in cooperation with our own Committee on Emergency Medical Service. With the worsening of the international situation, it has been repeatedly emphasized that every American community should set up a Civil Defense organization ready to go into action on a moment's notice. Although it is difficult to persuade some that such action is essential, yet it must be recognized that the lay public has become deeply concerned over the potential danger and looks to the medical profession to take its major share of responsibility and to provide reassuring evidence of its willingness and readiness to provide the care that will reduce loss of life in case of enemy attack on our cities. That applies, not alone to Chicago and Peoria and East St. Louis, but to every community in the state. Failure to provide such reassurance would be highly detrimental to the medical profession. That is why this committee is concerned with this work.

Through the efforts of the medical committees charged with such responsibility, we are able to say, the medical profession is ready and organized. Without going into details already covered by the report of the Committee on Emergency Medical Service, we will recount here the important fact that the medical and allied professions of Chicago are ready for emergency and the downstate communities are rapidly falling into line with their own contributions. The committee is happy to commend the effort of Dr. A. C. Ivy, deputy civil defense director in Chicago, and of Dr. Earl H. Blair, chairman of the Committees on Emergency Medical Service of both the Illinois State and Chicago Medical Societies.

With the approval of the Committee also, Mr. Leary has been made chairman of the sub-committee on Medical Information of the Chicago Civil Defense Corps and has given a great deal of time and energy to this work.

As a part of that effort, there has been organized a statewide committee of the major women's organizations, including our own Woman's Auxiliary, through which full public appreciation of the importance of medicine's major contribution to Civil Defense can be obtained and cooperation in the public education effort so essential to success may be achieved.

One of the major problems of Civil Defense is to recruit the thousands of trained nurses who would be required in case of catastrophe. That problem is now being put up to the women's civil defense committee. With the enthusiastic cooperation of the Woman's Auxiliary to the Illinois State Medical Society, a questionnaire was sent out to its membership from the public relations office asking every member to list all usable skills and training, especially in the nursing field. More than 20 per cent of the 2,500 copies of the questionnaire sent out have been returned and are now being tabulated. So successful has their questionnaire been that it is now being circulated among the other women's groups with such suggestions that they follow the example of our Woman's Auxiliary.

Great credit is due Mrs. Carl E. Sibilsky of Peoria, president, to Mrs. W. W. Young of Chicago, second vice president and public relations chairman of the Woman's Auxiliary to the Illinois State Medical Society and Mrs. G. W. Lawson of Chicago, vice president of the Woman's Auxiliary to the Chicago Medical Society, and the many other officers of auxiliaries throughout the state for their cooperation in this effort.

Meanwhile some 3,000 women's organizations throughout the state, reached through their state officers, have appointed Civil Defense Committes and stand ready to cooperate, with the medical profession of Illinois and their local Civil Defense Corps in the medical side of the program.

In addition, our public relations director worked with Dr. Blair in setting up an elaborate exhibit on Civil Defense at the Clinical Conference of the Chicago Medical Society, which was viewed by some 2,400 persons. A similar exhibit is being planned for the state meeting.

WOMAN'S AUXILIARY.—The Civil Defense program, however, was not the only major instance of fine cooperation in our public relations program provided by the Woman's Auxiliary. They also gave a fine example of their value in last year's get-out-the-vote campaign and undoubtedly consti-

tuted a major factor in its successful outcome. The value of their contributions cannot be over-estimated and, speaking from the public relations standpoint, it is our hope that communities still without auxiliaries will soon organize them. Their sincerity and enthusiasm have been devoted untintingly to the programs of the medical profession.

Our office staff has given considerable time to assisting, on request, the work of the Auxiliary in setting up programs, getting out notices and providing news releases to press and radio of the state.

OUTSTANDING GENERAL PRACTITIONER. —As is usual, the selection of the outstanding general practitioner provided one of the major publicity opportunities of the year. Dr. Ernest E. Davies of Avon is a colorful individual whose personal and professional achievements attracted attention from nearly every newspaper and radio news service in the state. A general news story was released as soon as the selection was made known, then the story of his life was obtained from him and presented to the American Medical Association trustees at the Clinical Session in Cleveland in December. He was not, unfortunately, chosen for national honor, as was his predecessor, Dr. Andy Hall of Mr. Vernon, but he deserved it equally and he won much credit for the medical profession in Illinois.

Dr. Hall, meanwhile, rounded out his year in December with his customary incredible verve and the publicity his sparkling personality engendered it still echoing among the magazines and radio programs.

ANIMAL RESEARCH. — Medicine's battle against the antivivisectionists who would destroy medical research continued unabated. In addition to Mr. Neal's work in supporting the "dog-pound bill" (H. B. 490) in Springfield, Mr. Leary cooperated with the Illinois Society for Medical Research in many ways. The facilities of our office, such as mailing lists, addressograph plates and information files were made available and used frequently and they made numerous suggestions which were well received and we issued news releases setting forth the Society's position in support of the bill.

PAMPHLETS.—No news pamphlets were issued during the year, but "Doctors and Horses," prepared in 1947 at the direction of Dr. Harlan English of Danville, chairman of our Committee on Rural Medical Service, was revised and brought up-to-date. This pamphlet sets forth the Society's program for improving and enlarging rural medical care and outlines our plan of loans to finance medical education for intending rural practitioners. It has maintained a surprising popularity, not only in Illinois but all over the nation. This is the fourth revision which has been necessary. More than 30,000 copies have been distributed, many thousands of them by the American Medical Association, while the Illinois Department of Public Health recently requested and received another thousand copies for distribution in its health education work.

HEALTH COUNCILS.—One of the local activities the Society has brought to the attention of county societies is the formation of local health councils. Such groups, which bring the medical profession and lay organizations together to cooperate for community welfare, are also recommended by the American Medical Association and a number of communities have them.

This activity has received considerable stimulus in the last year through a program instituted by the Chicago Blue Cross Plan, whereby residents of willing rural counties are being organized into "Health Improvement Associations."

Though the Plan's object is to set up groups which are eligible for group hospital insurance, they also function as health councils. Nearly 40 are already in operation. This is an interesting development which warrants the cooperation of local medical societies, as this committee is cooperating. Our public relations director attended a meeting in Peoria in January at which representatives of most of the Health Improvement Associations were present and voted to form a statewide Health Improvement Association council.

CONCLUSION.—These are the high spots of the committee's work for the year. There are many other topics that might be touched on—our continuing cooperation with the campaign to expand further tuberculosis control throughout Illinois; work with students at the high school level desiring debate and essay material on socialized medicine; assistance being given to child health programs; aid supplied to Macoupin County in its difficulties with a St. Louis paper; the coverage of the annual meeting; the day-to-day grind of telephone and personal demands for aid, advice or service—but these are relatively minor details, accepted as routine responsibilities of the office maintained by the Committee, and we pass them and others over thus in the interest of brevity.

We conclude our 1950 report with a plea for fullest understanding and cooperation from every member of the Illinois State Medical Society. The response was deeply gratifying and its results bore out our confidence in the patriotism and professional dedication of the medical profession of Illinois. But the end is not yet. The war still goes on. International crises offer our adversaries opportunity to try again and again to enslave us and we cannot by any means afford to rest on our laurels. We will need even greater effort on the part of every individual member and every county society through the next year, but we unhesitatingly place our trust still in the medical men of Illinois and their allies.

Respectfully submitted, PERCY E. HOPKINS, M. D., *chairman,* EDWIN S. HAMILTON, M. D., EVERETT P. COLEMAN, M. D., *Ex-Officio:* HARRY M. HEDGE, M. D., *President,* HAROLD M. CAMP, M. D., *Secretary. Advisory:* JOHN W. NEAL, *Executive Secretary,* JAMES C. LEARY, *Director of Public Relations.*

MEDICO-LEGAL COMMITTEE

The work of this Committee continues along the same line as that reported one year ago. Records and observations seem to indicate that the vast majority of our members have secured for themselves adequate medico-legal protection.

Since threats and suits come when least expected and from the most unlikely source, good sense and sound judgment would naturally prompt such a course.

The usual number of calls for assistance have come to the Committee but no requests for court attendance have been received.

Respectfully submitted, OSCAR HAWKINSON, M. D., *Chairman.* A. L. NICKERSON, M. D., PLINY R. BLODGETT, M. D., F. E. BIHSS, M. D., DARWIN B. POND, M. D., RALPH McREYNOLDS, M. D., *Medico-Legal Committee.*

COMMITTEE ON ARCHIVES

The Committee on Archives is a permanent committee of the House of Delegates, established to maintain a running history of the Society, and to assist in preserving items of historical interest to members of the medical profession.

During the past year the Committee on Archives has met with the Committee on History. Both of these committees are conducting overlapping activities to some extent at this time. Data for use in the publication of the second volume of the History of Medicine in Illinois, is being collected.

The Committee is anxious to have all members of the Society contribute any item of interest, any biographic sketch, any old books which might be of value, to the Committee. The files are kept in the John Crerar Library in the name of the Society, and the Committee members ask the county medical societies to give assistance in any way possible at any time.

Respectfully submitted, D. D. MONROE, M. D., *Chairman,* J. J. MOORE, M. D., E. H. WELD, M. D., DAVID J. DAVIS, M. D., *Historian, Ex-Officio, Committee on Archives.*

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

The Committee has met several times during the past year and considered various problems referred to it by the Council.

THE GENERAL HOSPITAL SITUATION

Table I. gives a summary of hospital data for the country in 1949 and Table II. gives a summary of the growth of hospitals in the United States from 1909 to 1950. Since the war there has been an actual reduction in the total number of hospital beds by the reduction in the number of beds in military hospitals. Some increase is now occurring because of the expansion of our Army, Navy and Air Force. A slow but consistent increase may be noted in the total number of beds in civilian hospitals. In Illinois the total number of beds in hospitals during 1950 increased from 97,163 to 99,388.

Further expansion of hospital facility is urgently needed, but the cost of construction continues to be a serious deterrent. It requires on the average about $20,000.00 to provide one bed in a hospital. Most hospitals are operated on a non-profit basis, and their construction is therefore not an attractive venture for loans. The result is that a large part of the cost of construction must be available before building is started.

TABLE I.

SUMMARY OF HOSPITAL DATA—1949

All Registered Hospitals	
Number	6,572
Bed Capacity	1,439,030
Bassinets	89,386
Patients Admitted	16,659,973
Births	2,820,791
Average Daily Census	1,224,951
Patient Days	447,107,115
General Hospitals	
Number	4,761
Bed Capacity	574,683
Bassinets	85,502
Patients Admitted	15,450.311
Births	2,744,268
Average Daily Census	429,443
Patient Days	156,746,695

A few examples of the difficulties encountered may be mentioned. The new Mercy Hospital, for which plans were developed a few years ago, is still in the planning stage. The Presbyterian Hospital has held up its construction plans indefinitely because its campaign for funds did not go as well as expected. Many small well-run private hospitals which are seriously overcrowded are unable to proceed with expansion because of lack of funds.

On the other hand, there are many specific examples of progress. The Columbus Hospital has recently added a large new wing. The Masonic Hospital has just completed a large addition. A new cancer hospital was opened at the University of Chicago. A new veterans hospital is now being built near the Northwestern University Medical School and another in the Medical Center is rapidly expanding as shown by the fact that construction is now under way on a large addition to the Research and Educational Hospital, a new tuberculosis hospital, a new steam plant to provide heat to buildings in the Medical Center, the Cook County Postgraduate School of Medicine and the new building for residents and interns of the Cook County Hospital.

THE COST OF HOSPITALIZATION—The cost of hospitalization increased a little more in 1950. The rapid increase in the cost of hospitalization which has occurred in recent years has made it difficult for the various health insurance plans to estimate their rates. The cost of hospital insurance has steadily risen.

The high cost of hospitalization is largely beyond the control of the medical profession. For most patients in hospitals the hospital bill is usually much larger than the bill for medical services.

The medical profession can help to reduce the total cost of medical care and also relieve the shortage of hospital beds by admitting to the hospital only those patients who cannot be cared for in doctors' offices. Many patients who are admitted to the hospital for

TABLE II.—SUMMARY OF GROWTH OF HOSPITALS, 1909 TO 1950

	Federal Hospitals		State Hospitals		All Other Hospitals		Total	
Year	No.	Capacity	No.	Capacity	No.	Capacity	No.	Capacity
1909	71	8,827	232	189,049	4,056	223,189	4,359	421,065
1914	93	12,602	294	232,834	4,650	287,045	5,047	532,581
1918	110	18,815	303	262,254	4,910	331,182	5,323	612,251
1923	220	53,869	601	302,208	6,009	399,645	6,830	755,722
1928	294	61,765	595	369,759	5,963	461,410	6,852	892,934
1931	291	69,170	576	419,282	5,746	485,663	6,613	974,115
1932	301	74,151	568	442,601	5,693	497,602	6,562	1,014,354
1933	295	75,635	557	459,646	5,585	491,765	6,437	1,027,046
1934	313	77,865	544	473,035	5,477	497,201	6,334	1,048,101
1935	361	83,353	526	483,994	5,404	507,792	6,246	1,075,139
1936	323	84,234	524	503,306	5,342	509,181	6,189	1,096,721
1937	329	97,951	522	508,913	5,277	517,684	6,128	1,124,548
1938	330	92,248	523	541,279	5,313	527,853	6,166	1,161,380
1939	329	96,338	523	560,575	5,374	538,113	6,226	1,195,026
1940	336	108,928	521	572,079	5,434	545,238	6,291	1,226,245
1941	428	179,202	530	600,320	5,400	544,859	6,358	1,324,381
1942	474	220,938	530	606,437	5,341	556,452	6,345	1,383,827
1943	827	476,673	531	610,115	5,297	562,466	6,655	1,649,254
1944	798	551,135	539	609,025	5,274	569,785	6,611	1,729,945
1945	705	546,384	549	619,642	5,257	572,918	6,511	1,738,944
1946	464	264,486	557	628,363	5,259	575,865	6,280	1,468,714
1947	401	213,204	563	626,648	5,312	585,370	6,276	1,425,222
1948	372	185,098	567	648,386	5,396	590,036	6,335	1,423,520
1949	361	182,254	573	656,611	5,638	600,165	6,572	1,439,030
1950	355	186,793	552	665,019	5,523	605,100	6,430	1,456,912

diagnostic problems can be handled fully as well outside of the hospital. Adherence to this plan would also reduce the cost of hospital insurance. In the past many patients with Blue Cross insurance who required diagnostic x-ray and laboratory work have been admitted to the hospital for this purpose, in spite of the fact that diagnostic admissions are supposedly not allowed under the Blue Cross plan.

A rather sharp line of cleavage has unfortunately developed between the medical profession and the American Hospital Association. When the American College of Surgeons discontinued its certification of hospitals, the American Hospital Association tried to play a dominant role in the joint plan set up between its own organization and the American Medical Association, the American College of Surgeons and the American College of Physicians.

The administration of hospitals is largely in the hands of non-medical personnel, and physicians are not supposed to know anything about the problem. It has been recommended that physicians should not be allowed to serve on Boards of Trustees of hospitals. Physicians are reappointed to hospital staffs each year and, while reappointment is usually automatic, arbitrary decisions to drop staff members are often made. The physician who is dropped has no recourse, and there is no obligation on the part of anyone even to give him a hearing. While the yearly tenure has many advantages, it often works definite hardships on individual physicians. It is difficult for the Committee to understand why members of the medical profession cannot serve on the Boards of Trustees of institutions whose management concerns them vitally.

THE ROLE OF THE HOSPITAL IN MEDICAL EDUCATION—The training of physicians is usually carried out in hospitals after the completion of four years of training in medical schools. The standards of medical care in hospitals have gradually improved, and hospitals have become more and more diversified in their activities.

Many leading hospitals have excellent research facilities in which outstanding investigations are conducted on the cause and treatment of disease. The fundamental nature of investigation in hospitals is often equal to or better than that conducted in fundamental science laboratories in medical schools.

With the growing importance of the hospital there have already occurred some changes in medical practice with which the American Medical Association is not entirely in sympathy. Departments of roentgenology, clinical pathology and anesthesiology are often run by fulltime employees of the hospital. Their compensation is relatively small and the profits go to the hospital.

In some instances hospitals have tried to enter other phases of medical practice in direct competition with members of their own staffs and with other doctors in the community. Many hospitals have established diagnostic clinics for patients in relatively low income groups. They have in some instances broadened their

scope to include people in all income brackets. Hospitals can render this service only by competing with their own staffs. Services of this type represent the practice of medicine by a corporation, regardless of how they are set up. It would seem wise in most instances for hospitals as corporations to refrain from entering the practice of medicine. This point of view is not in conflict with the idea of centralizing the activities of physicians by having office buildings in close proximity to hospitals.

Hospitals can perform a valuable service in the education of the physician by providing the following:

1. An adequate training program for interns and residents which should include both didactic training and its practical application in the care of patients.

2. Clinical-pathologic conferences and scientific meetings to develop diagnostic acumen and keep members of the staff familiar with recent developments in medicine.

In larger hospitals departmental meetings have been encouraged and give the men in each field of medicine as opportunity to discuss mutual problems. These serve as a supplement to scientific meetings of the whole staff.

Wherever possible, medical schools should expand their sphere of usefulness by developing teaching arrangements with as many hospitals in the community as possible. The combined effort of the medical school and the hospital results in better training programs and makes it possible to secure better interns and residents and a better staff.

The medical schools of state universities have a particular responsibility in this regard. They have the opportunity to aid in setting up training programs for interns and residents in many hospitals throughout the state and to aid in the development of postgraduate courses for members of these hospital staffs.

THE GENERAL PRACTITIONER—Adequate programs for the development of medicine can be developed only by making adequate provision for all members of the profession. The general practitioner has presented a special problem in the last few years. It has often been difficult for him to secure adequate hospital appointments and to take care of his patients in the hospital.

The establishment of the American Academy of General Practice represents a desirable development. Standards for the general practitioner are being set up as well as special types of training programs and postgraduate courses for keeping up to date. The Academy requires proof of attendance at 150 hours of postgraduate study every two years. Physicians are licensed to practice medicine and surgery in all its branches, but the profession must make sure that patients receive the highest possible type of medical care.

Both the general practitioner and the specialist must keep constantly up to date, and a certain standard of proficiency in each field of medicine must be maintained if patients are to secure adequate care. Programs should be set up that will make it possible for the general practitioner to be just as proficient in his field as the specialist is in his. It is particularly important to devise some mechanism whereby physicians will get credit for work in general practice if they later wish to enter a specialty.

Several hospitals have established Departments of General Practice, and this policy should be encouraged.

INTERNSHIPS AND RESIDENCIES—There are many more approved internships available each year than there are graduates of medical schools to fill them. The result is that many hospitals are unable to fill their quota of interns, whereas the large teaching hospitals have an abundance. It has been suggested that the teaching hospitals eliminate internships and concentrate on residencies. However, intern training in teaching hospitals is usually of such a high caliber that there is a great demand for it.

TABLE III.
APPROVED HOSPITALS, INTERNSHIPS AND MEDICAL SCHOOL GRADUATES, 1940-1950

Year*	No. Hospitals	No. Internships	No. Graduates
1940	732	7,998	5,097
1941	735	8,182	5,275
1942	740	8,353	5,163
1943	760	8,180	5,233
1944**	766	5,602	10,303***
1945	785	8,429	5,136
1946	798	8,584	5,826
1947	764	8,539	6,389
1948	807	9,118	5,543
1949	799	9,124	5,094
1950	799	9,398	5,600 (Estimated)

Year of publication.
**Quota year.*
***Includes 2 classes.*

(U. S. Army, U. S. Navy Hospitals and those outside the United States not included in 1940 to 1947 figures.)

In Table III. is recorded the number of approved hospitals, internships and medical school graduates from 1940 to 1950. It may be seen that in 1950 there were 9,398 internships available and only 5,600 approximately to fill them. In the state of Illinois in 1950 there were 62 approved hospitals, 702 internships available and 98 vacancies (14%) reported.

The internship problem is a very serious one, and no solution is in sight. The demand for interns will undoubtedly increase faster than the number of medical school graduates. Some mechanism must be worked out which will provide hospitals with interns or some other group of medical workers who can take their place. Elimination of the internship in teaching hospitals would help to solve the problem, but it would be only a partial solution, and it is debatable whether or not such a procedure is wise.

During 1950, 63 hospitals in the country (9%) did not pay any salaries to their intern staffs, whereas 293 hospitals (40%) paid $50.00 or less per month, 283 (39%) offered amounts ranging from $51.00 to $100.00 and 89 (12%) paid amounts in excess of $100.00. The comparable percentages for 1949 were 13, 40, 33 and 9 per cent respectively.

Payment of interns is desirable because of the long period of time involved in the development of proficiency in medicine. After the completion of four years of college and four years of training in a medical school a physician should be entitled to some remuneration, particularly in view of the fact that he renders such valuable service to the hospital.

During 1950, 4,292 hospitals were approved for residency training and offered 18,669 residencies and reported 1,179 vacancies. The great demand for residency training which followed the Second World War has now been largely met.

THE MEDICAL SCHOOLS OF ILLINOIS—Illinois continues to have five approved medical schools, namely those connected with Northwestern University, the University of Chicago, the University of Illinois, Loyola University and the Chicago Medical School, which is unattached. They graduate each year a total of approximately 660 doctors. Most of them have increased their enrollment slightly during the last year, but the facilities for expansion in the enrollment are very limited.

Chicago has become more and more of a medical center. There is excellent cooperation between the schools and the Illinois State Medical Society, and it is very important that this spirit of cooperation continue.

The cost of medical education which was outlined in our report last year has continued to be a serious problem with most of the privately endowed schools running at a deficit which must be met out of general university funds. This state of affairs cannot continue, and some method must be found to meet this deficit, which has been estimated at somewhere between $10,000,000 and $17,000,000 a year. A group of leading business men was formed to raise money for this purpose, but their activities have not been very fruitful up to the present time.

At the interim session in December, 1950, the American Medical Association set aside the sum of $500,000, which it was hoped would form the nucleus of a much larger sum to be pooled among the medical schools of the country. Additions to the fund of the American Medical Association have been very limited and will probably continue to be unless doctors assume the responsibility of meeting the medical school deficit each year by assessing themselves an adequate sum to meet the deficit.

One hundred dollars a year from each practicing physician in the country would provide a yearly sum of approximately $15,000,000. By an action of this sort the doctors of the country would make federal funds for the training of medical students unnecessary and would keep the federal government from controlling the supply of doctors.

The alumni of Yale Medical School have illustrated what may be accomplised. In 1950 they raised $700,000 to meet the deficit of the Medical School of Yale University, and it is their hope that they might be able to raise even more in 1951.

An appeal to the doctors themselves to meet the deficit in medical education is fair and proper because, as medical students, they pay only a small fraction of the cost of their medical education. Once they have become established in practice there is no reason why they should not return to the schools through yearly contributions the money which was spent in their education. An arrangement of this type would make the physicians of the country much more vitally interested in the problems of medical education and would help to keep the control of the medical schools where it properly belongs, namely, in the medical profession itself. It would bring the schools and the profession as a whole together and make the schools much more conscious of their obligation to the profession.

PART-TIME VS. FULL-TIME IN CLINICAL MEDICINE—Following the Johns Hopkins example about forty years ago, the medical schools in the country began to develop a nucleus of full-time teachers. Men were usually made full-time heads of clinical departments largely on the basis of some investigative work which was thought to be creditable. It was felt that their full-time status would give them adequate time for teaching and research. However, in most instances they became so burdened with administrative responsibilities that their investigative work ceased and teaching became a sideline. Much of their administrative responsibility has involved attention to petty details and committee meetings which could easily be handled by some administrative officer under the supervision of the department head.

The full-time teachers in medical schools have in most instances been men who have not practiced medicine, and they have usually remained somewhat isolated from men in practice and have considered themselves a superior group of individuals. They have usually not taken much part in the activities of their county and state medical societies and have in many instances frowned on these activities. Much of the important support for socialized medicine within the profession itself has come from full-time teachers of medicine.

In the last fifteen years the pendulum has swung in the opposite direction and, at the present time, 90% of the so-called full-time men on medical school faculties now have practice privileges. This change has come about largely because it has been found by actual experience that men who do some practice make better teachers and to some extent because the medical schools have not been able to pay large enough salaries to keep their best men on a full-time basis.

Medical students should be taught how to apply fundamental knowledge to medical practice by physicians who actually practice themselves. Teachers in medical schools should be an integral part of the profession and should mingle with the profession and know their problems. They can be thoroughly familiar with these problems only by sharing them themselves in actual practice.

It is unfortunate that our own state medical school, the College of Medicine of the University of Illinois, has seen fit to go against the trend and has definite plans to fill each vacancy that occurs in the headship of a clinical department with a strictly full-time man

who will have no practice privileges. Most of the physicians of the state are very much opposed to this policy, and it is sincerely hoped that the University of Illinois will give serious attention to their point of view. The University of Illinois was developed to serve the citizens of the state, and it cannot ignore their wishes and succeed. The clinical faculty of the state medical school has an obligation not only to the charity patients of the state but also to private patients who wish to pay their own way.

Full-time is a myth anyway. Most leading physicians, chemists, mathematicians, economists and teachers in engineering schools in universities throughout the country do consultation work for which they get paid a fee in addition to their full-time salaries. Many full-time teachers of medicine assume responsibilities outside of the university which often involve as much as 50% of their time, but they continue to be paid full-time salaries for full-time jobs.

These outside responsibilities are good for the university and increase the service of the university to the community. The main point is that an outstanding teacher has so many demands made upon him that he cannot possibly serve more than part-time for the university. Department heads should be picked on the basis of their ability and not on the basis of whether or not they are willing to conform to a system.

HEALTH INSURANCE—Blue Cross and Blue Shield have continued to expand their activities as non-profit plans for hospital and medical care, respectively.

The Blue Cross Plan in Chicago lost $2,000,000 in 1950 and, as a result, had to discontinue x-ray service in hospitals. A large part of the difficulty was caused by the admission of patients to hospitals for various diagnostic procedures including x-ray work which was actually contrary to the provisions of the Blue Cross contract. It is very important that Blue Cross and Blue Shield remain solvent and very important for the doctors to cooperate in every way possible to make these plans work.

The Chicago Blue Shield Plan changed its name to Illinois Medical Service in order to take in various counties in the state as arrangements can be made to do so. The number of subscribers increased greatly during the year, and the Plan is now working well and appears to have the cooperation of the physicians of the state.

There are still many problems to be solved. It is important that Blue Cross and Blue Shield be made available to individual subscribers rather than to members of groups only. Provision must be made for serious illness which incapacitates an individual for a long period of time. Special policies will have to be developed for this purpose. The Blue Shield Plan needs to be expanded as soon as possible to provide more extensive coverage.

It is hoped that the commercial insurance carriers will enter the field of health insurance activity and develop better and better policies so that adequate coverage will be available to most people.

There is one point which deserves the most serious consideration. There has been a tendency recently for Blue Cross and Blue Shield to attempt to dictate to the profession. They are scrutinizing very carefully the drugs that doctors use in hospitals and showing some tendency to dictate fees. As the number of subscribers becomes larger and larger, the health insurance plans will undoubtedly attempt more and more to dictate policies of medical practice. Between the hospitals and the health insurance plans the time may come when physicians will have very little to say about the thing which concerns them most, namely, the practice of medicine.

The whole spirit of free competition demands that health insurance should not be dominated by one group. Many insurance companies should compete freely in an open market so that the public will get the best possible service and the greatest return on its dollar.

POSTGRADUATE MEDICAL EDUCATION—With rapid developments in medicine the continuing education of the physician becomes a more and more important problem. The Illinois State Medical Society, through its Annual Meeting and its Postgraduate Days, and the Chicago Medical Society, through its Annual Clinical Conference, its Postgraduate Courses and its scientific meetings, continue to play an important role in postgraduate education. The postgraduate activities of the Illinois State Medical Society and of the Chicago Medical Society may have to be expanded to meet the demand for training.

The medical schools of the state in cooperation with the American Academy of General Practice have set up training programs for the general practitioner, and the University of Illinois has expanded its activities to include many communities in the state. The cost of this education is provided for by the general practitioners themselves.

THE OSTEOPATHIC PROBLEM—There is a bill now pending in the state legislature to set up a separate Osteopathic Board of Registration, consisting of five members, to examine and license osteopaths to practice medicine and surgery in all its branches. Such a development would lower the standard of medical care in the state.

The Chicago Osteopathic School has made attempts from time to time to become approved as a school of medicine. Their equipment and faculty are far below the standards of approved medical schools.

It is unfortunate that so many schools closely allied to medical schools have been developed. However, the problem must be dealt with as it actually exists. The osteopaths have a strong organization, and they have attempted to raise the standards in their schools and have set up specialty boards within their own organization. It would be desirable if some mechanism could be found to bring the osteopathic schools together, but the practical difficulties appear insurmountable at the present time. The main difficulty is that enough money is not available to bring the osteopathic schools up to the standards of medical schools.

Dr. Ivy has been greatly interested in this problem and wrote to Mr. Holloway of the American Medical

Association for information. Mr. Holloway has written to Dr. Ivy under date of October 18, 1950 as follows:

"I think an explanation is due you for this delayed response to your letter of July 20 in which you submitted some eight questions relative to osteopathy. At the time that your letter was received, our memoranda embodying analyses of the state osteopathic laws were undergoing revision to bring them up-to-date. Following the completion of these revisions, which incidentally consumed considerable time, I was away from Chicago for about two weeks and am just now catching up with accumulated work. Really I should have acknowledged the receipt of your letter and should have let you know that there would be a delay in supplying the information you requested.

"Even now I doubt whether I can give you a complete response to your several questions but I shall do the best I can.

"1. I doubt if there has been any increase in the number of states, during the last fifteen years, in which osteopaths may obtain a license to practice. In all of the states at the present time, osteopaths may obtain the legal right to practice according to the limitations, if any, imposed by the state laws. I believe that the same situation obtained fifteen years ago.

"2. I am enclosing a memorandum which will indicate the states in which oseopaths are examined by their own boards and those states in which they are examined by so-called composite boards.

"3. Under separate cover I am sending to you our revised memorandum indicating the scope within which osteopaths may practice in the several states. This memorandum will indicate the jurisdictions in which osteopaths may utilize drugs. You will note that in many states the law simply authorizes osteopaths to practice osteopathy, or osteopathy and surgery, without referring specifically to the use of drugs. Under such circumstances the courts have held without any exception that I recall, that osteopathic licentiates may not use drugs for remedial purposes. In the memorandum you will find references to one or two leading cases in which this issue has been involved.

"4. The Educational Supplement to The Journal of the American Osteopathic Association for January, 1950, lists 65 registered osteopathic hospitals approved for the training of interns. It also lists additionally under the classification 'Registered Osteopathic Hospitals' 99 institutions, but there may be some duplications in the two lists.

"5. I cannot give you the increase in the number of osteopathic graduates in relation to the increase in the number of allopathic graduates without a considerable amount of research work that we cannot do at the present time unless there is some very urgent need on your part for the information. To obtain this information, of course, it would be necessary to study the catalogs of the six accredited osteopathic schools year by year and also the catalogs of the medical schools in like manner. I would not be surprised, however, if there has not been a gradual increase in the number of osteopathic graduates but how this increase would compare with the increase of graduates of accredited medical schools, I simply do not know.

"6. Neither can I give you information as to the number of individuals *applying* for admission to osteopathic schools at the present time. Possibly information could be obtained as to the number in the freshman classes of the six schools during the last several years but this would not necessarily reflect the number *applying* for admission.

"7. I am a little uncertain about the meaning of this question. You ask for 'the increase in the number of colleges and universities giving the combined degree for 1 year in an osteopathic college.' I know of no school that confers both the degree of doctor of medicine and doctor of osteopathy. If you clarify this question, perhaps I might be able to give a more responsive reply.

"8. During the last fifteen years osteopaths have made determined efforts to gain acceptance in the medical corps of the Army and Navy, in the Veterans' Administration and in the Public Health Service. They have been enacted under which a discretionary power has been conferred on appropriate agencies to accept osteopaths in the Veterans' Administration, in the Army and Navy medical corps and in the Public Health Service. None of these laws make it mandatory to employ osteopaths and I understand that in the Veterans' Administration a few of such practitioners have been accepted but they, according to the information I have, do not function in the supplying of actual treatment to veterans but are used in administrative capacities in regional offices. I believe, too, that a few osteopaths may have been employed by the Public Health Service but here again their services were used not for treatment purposes but as inspectors.

"So far as the general status of osteopathy is concerned, during the last fifteen years they have succeeded in a number of states in obtaining quite broad privileges. This has been true in Indiana, Ohio, Wisconsin, New York, and New Jersey, to mention a few of the outstanding instances. We do have in our files some notes we prepared in 1935 outlining the scope of osteopathy, by states, as of that time. Our present memorandum embodies the scope at the present time and if you would like to send some one to the office to make a check, you could readily ascertain the changes that have taken place since 1935.

"I hope that this letter will contain in the main the information that you want. If not, write me and I promise not to delay by response as long as I delayed the answer to your July letter. Sincerely yours, Signed J. W. Holloway, Jr."

He has appended to his letter the following memorandum:

MEMORANDUM SHOWING METHODS IN FORCE IN THE SEVERAL STATES FOR REGULATING THE PRACTICE OF OSTEOPATHY

Prepared by the Bureau of Legal Medicine and Legislation, American Medical Association, July, 1945. Corrected to May 31, 1950.

1. *States having independent osteopathic boards which pass on the educational and moral requirements of applicants, conduct examinations and issue licenses to practice.*

Arizona (1)	Montana
Arkansas (1)	Nevada
California	New Mexico (1)
Florida (1)	North Carolina
Georgia	North Dakota
Kansas	Oklahoma (1)
Louisiana	Pennsylvania
Maine	South Carolina
Maryland	South Dakota (1) (B)
Michigan (1) (A)	Tennessee (1)
Minnesota (1)	Vermont
Missouri	West Virginia

2. *States in which a separate board of osteopathic examiners operates under the supervision of a central licensing department or bureau.*

Connecticut (1)	Nebraska (1)
Idaho	Rhode Island (1)
Iowa (1)	Utah
	Washington (1)

3. *States in which osteopaths are examined and licensed by the medical examining agency on which there is osteopathic representation.*

Colorado (1) (C)	New York
*District of Columbia (1)	Ohio
Illinois	Oregon (1)
Indiana	Texas
Kentucky	Virginia
New Jersey	Wisconsin (1)
	Wyoming

4. *States in which osteopaths are licensed, under special conditions, by the state medical licensing board, on which the osteopaths have no representation.*

Alabama	Mississippi

5. *States in which osteopaths are required to take the regular medical examination before the state medical licensing board, on which osteopaths have no representation.*

Massachusetts	New Hampshire

6. In Delaware, osteopaths are examined by the medical council, consisting of the Chief Justice of the State, the president of the *regular* examining board and the president of the *homeopathic* examining board, together with an osteopath selected by the council.

**Licenses are issued by the Commission on Licensure to Practice the Healing Art.*

(1) Applicants must pass an examination in the basic sciences, given by a basic science examining board, before they are permitted to take their professional examinations.

(A) The Michigan basic science act does not apply to any person matriculated in any medical, osteopathic or chiropractic school or college on or before October 15, 1937.

(B) The South Dakota basic science act does not apply to students regularly registered, enrolled and in attendance as of March 15, 1939, in medical, osteopathic and chiropractic schools recognized and approved, respectively, by the State Board of Health, the National Osteopathic Association and the State Board of Chiropractic Examiners.

(C) The Colorado basic science act does not apply to persons who graduated between January 1, 1936, and July 1, 1937, from schools of the healing arts approved, as of July 1, 1937, by the respective licensing boards of Colorado, if such persons had not been, prior to July 1, 1937, licensed to practice in any other State, Territory, or the District of Columbia. Furthermore, the act does not apply to persons who graduate prior to July 1, 1940, from schools which were so approved on July 1, 1937, and in which such persons were regularly matriculated as resident students prior to July 1, 1937.

THE NURSING PROBLEM—The nursing shortage which became acute during the Second World War has not been satisfactorily dealt with. Some improvement occurred after the War, although the supply of nurses has remained inadequate. The shortage has become more acute again during the last year.

Many states have made provision for the training and licensing of practical nurses. A bill for this purpose is now pending in the Illinois state legislature. The period of training is one year, and requirements for admission are much lower than for schools of nursing education. The Practical Nursing Bill in Illinois has received the endorsement of the Illinois State Medical Society and of the Illinois State Hospital Association.

This development has come about because of the serious nursing shortage and because of the realization that many routine functions which in the past have been performed in hospitals by registered nurses can be adequately handled by persons with less specialized training. On the other hand, it is difficult to see how the licensing of practical nurses can fail to lower the standard of nursing care.

It would seem much more logical to provide various steps in the training of registered nurses which would represent steps in a comprehensive training program. Students might complete enough training at the end of two or three years to carry out all routine nursing responsibilities and might later if they wish to use the credit thus obtained toward more advanced training.

Some officials of the American Nurses Association would like to eliminate all small schools of nursing education and preserve only those associated with universities. This would be a very short-sighted policy, because many of the best nurses come from smaller nursing schools where they are given more practical training than in the larger nursing schools.

Any attempt to limit nursing education to women who plan to complete their work for a college degree would not solve the problem in nursing education. The great need is for nurses with sufficient training to give sick people adequate nursing care. It is important to develop as many highly-trained nurses as possible for administrative and teaching duties, but the main problem is an adequate supply of nurses who are sufficiently well-trained to care for people who are ill.

One of the main problems continues to be economic. Nurses are not paid salaries adequate for their training and responsibilities, and satisfactory provision is not made for the advancement of nurses who serve institutions faithfully for long periods of time.

One of the difficulties with the nursing profession is that the doctors have not taken enough interest in the nursing problem. Good nurses are very important people, and the medical profession should help in every way it can in the development of adequate programs of nursing education. Many of the differences of opinion between the American Nurses Association and the American Medical Association would disappear with adequate cooperation between the two organizations.

Respectfully submitted, W. O. THOMPSON, M.D., *Chairman,* A. C. IVY, M.D., HARLAN ENGLISH, M.D., *Committee on Medical Education and Hospitals.*

DR. JOSEPH SODARO, Forest Park: Dr. Hedge and Members of the House of Delegates: I asked for time because of a sentence on Page 84 of the Handbook, paragraph 2, "The internship problem is a very serious one, and no solution is in sight."

I would like to offer the following as a possible solution: that this Committee ask the House of Delegates to recommend to the A.M.A. to exert its influence on the Medical Schools to cause a distribution of interns to all qualified hospitals in these United States, the apportionment being based on the number of beds in each hospital.

The teaching hospitals can supplement their lack of interns by appointing more residents.

The reasons for the above recommendation are as follows:

1. The deficiency of interns in hospitals is causing a serious degenerating process in a large percentage of hospitals because the work that is usually done by interns is either neglected or poorly done by foreign substitutes.

2. This degenerating process could continue long enough to cause a lowering of standards of hospitals or directly disqualify them.

3. There is a question of whether it is the general practitioner or the specialist that "creates" a problem.

4. The patient in Podunksville is just as important as the patient in the Wesley Memorial Hospital or the Presbyterian Hospital.

5. Fast changing medicine is making today's specialist a horse and buggy doctor.

6. This entire situation is caused by a peculiar idea created by the leaders of medicine in the ivy-covered towers of our universities, exterting their influence on the thinking of the A.M.A. that a medical student is not a doctor unless he specializes. Theoretically, (and the schools are full of theory) men trained well in special divisions of medicine sound good; practically it doesn't work.

In conclusion — specialization means regimentation. Regimentation means socialization — the very thing we are all fighting against.

COMMITTEE ON MEDICAL BENEVOLENCE

If Dame Fortune were not such a fickle "Jade", there would be little need for our Benevolence Fund, but we do have daily reminders of her volatile disposition. Today one of our colleagues living in comfort and opulence, tomorrow accident, ill health or property loss may leave him with little besides a faint hope.

The number of our beneficiaries has increased the past year to 29; three applications now being processed. One year ago 22 were reported. The previous high was 25. Since life expectancy continues to increase from year to year with decrease in dollar value, we may well expect that there will be additional requests from our members who require aid.

The Committee tries diligently to evaluate all requests that are received. Our councilors, county officers and other members are constantly giving valuable advice and assistance. The councilor from the First District drove 75 miles to make an investigation while another drove 30 miles and found an aged physician colleague in the terminal stages of prostatic cancer, while the wife had been bedfast more than a year because of a hip fracture. A recent addition to our list is a young widow asking for temporary assistance while confidently seeking to establish herself in business. Maximum benefit continues to be $50.00 per month subject to Council approval. This amount can be increased upon recommendation of the Committee. At this time the average disbursement is approximately $40.00 per month or about $1,200 for our 29 members.

The Woman's Auxiliary should have grateful acknowledgment and commendation for the fine interest they are manifesting in this effort. The past year $5,354.00 have been received from this source. It might here be added that nothing is more befitting their activities and it is hoped their interest may continue to grow.

Doubtless the Society as well as each individual must feel well repaid for the small sacrifice made to maintain this one of its many useful projects.

Respectfully submitted, OSCAR HAWKINSON, M.D., *Chairman,* LEE O. FRECH, M.D., HAROLD M. CAMP, M.D., *Secretary.*

COMMITTEE ON MEDICAL TESTIMONY

For many decades the needs for some means of studying testimony in our courts of law with the view of correcting faults and discrepancies, have been discussed in various groups in our State with but little action taken. At the turn of the century, without doubt, the psychiatrist was the worst offender. An all-time high was reached in the Thaw trial in New York, when the cream of the psychiatric world was called to testify, one side seeking evidence of insanity in the accused while the opposing side diligently spent their time seeking all evidences of sanity. Both sides were more or less successful to the further confusion of court and jury with the result that in the ensuing years for one accused of major crime sooner or later as a last resort a plea of insanity by the defendant was presented to the court.

Massachusetts has a law known as the "Briggs Law," which provides for a commission appointed by the governor to examine into the sanity of the accused and report their findings to the court. This law is said to operate very well with a large saving to the Commonwealth.

Came the tremendous industrialization of our Nation along with rapid transportation with its attendant large number of accidental injuries, which found their way to our courts and other hearing bodies for adjudication. The surgeon and roentgenologist became the expert witness in overwhelming numbers with more frequent reasons for criticism and complaint.

While honest difference of opinion may exist without any criticism, there remains much evidence of ignorant, careless, and even dishonest testimony.

A number of years ago, the Minnesota State Medical Society had established a Committee on Medical Testimony, whose duty it was to study and, if possible, correct any testimony which might be harmful to the ends of justice. After much study, the House of Delegates decided that such a committee might serve a useful purpose in our own state.

From its earliest inception this Committee cherished high hopes that over the years its labors might become less and less. Established in 1947 as a standing Committee, its duties were readily outlined. For many years criticism had been leveled at certain men in our state who were called to testify in our courts of law. These criticisms frequently were well-founded and early in its activities a number of men were called to meet the Committee. Frank discussions were held with apparently salutory effects, and at this time it is with pleasure your Committee can report that no complaints have been received since May, 1950.

Respectfully submitted, OSCAR HAWKINSON, M.D., *Chairman,* EVERETT P. COLEMAN, M.D., WARREN W. FUREY, M.D., M. T. HORSMAN, M.D., WALTER L. PALMER, M.D., ARTHUR F. GOODYEAR, M. D., HARRY A. OBERHELMAN, M.D., E. H. WELD, M.D., *Committee on Medical Testimony.*

GRIEVANCE COMMITTEE

Surprisingly enough this Committee has nothing of startling importance to report.

The Committee is organized to receive and report on all complaints. About one-half dozen complaints have been received and in accordance with the main committee's wish the chairman has referred all for investigation, report and composure to the committees of the local societies.

I am happy to report that not a single lay complaint has remained unsettled and happily with complete satisfaction to all concerned.

I bespeak for each and every member of the committee our thanks for the fine cooperation and support from the doctors throughout the state.

Respectfully submitted, WALTER STEVENSON, M.D., *Chairman,* EVERETT P. COLEMAN, M.D., E. H. WELD, M.D., PERCY E. HOPKINS, M.D., IRVING H. NEECE, M.D., ROBERT S. BERGHOFF, M.D., *Grievance Committee.*

REPORT OF DELEGATES TO THE A.M.A.

REPORT ON THE SAN FRANCISCO MEETING OF THE AMERICAN MEDICAL ASSOCIATION

We will begin this report by giving some of the highlights of the San Francisco meeting of the American Medical Association. This meeting was one of the most successful in the History of the American Medical Association. It was held in the Palace Hotel in San Francisco, June 26th thru the 30th, 1950. There was something like 20,000 persons registered for the meeting in the first three days in San Francisco. Three major activities drew large attendance. The House of Delegates, which is made up of 198 members, created great interest. Many members of the medical profession outside of the delegates visited the House during its sessions to observe the action of this democratic body. Many resolutions and discussions were given by members of the House. Dr. Leonard Larson of North Dakota, who was later elected a Member of the Board of Trustees, gave a very detailed and complete report on the blood bank activities in the United States. He passed out a brochure outlining the status of the blood bank situation. The House passed on several important measures. Some of these were as follows:

Authorization of a student medical association which is to be inaugurated by the Board of Trustees;

Support of the World Medical Association;

There was a definite criticism of some hospitals which make membership in a specialty a requisite for appointment or advancement.

They also put their stamp of approval on continuation of the National Education Campaign during 1951 with the firm of Whittaker and Baxter as directors. In this case the Board of Trustees was authorized to proceed with expansion of the A.M.A.'s Department of Public Relations, and authority was granted to expand some of the special committees of the Council on Medical Service, this being in anticipation of eventual discontinuance of the National Education Campaign.

The House also voted to include subscription to The Journal in membership dues, which dues were set at twenty-five dollars for 1951, the same as for 1950.

The House of Delegates at election elected the following officers:

John W. Cline, San Francisco, California—President-Elect.

R. B. Robins, Camden, Arkansas—Vice President.

George F. Lull, Chicago, Illinois—reelected Secretary.

J. J. Moore, Chicago, Illinois—reelected Treasurer.

F. F. Borzell, Philadelphia, Pennsylvania—reelected Speaker of the House of Delegates.

Jas. R. Reuling, Bayside, New York—reelected Vice Speaker.

Leonard Larson, Bismark, North Dakota and Thomas P. Murdock, Meriden, Connecticut, to the Board of Trustees.

One of the outstanding features in connection with this San Francisco meeting was a national broadcast

hookup with the American Broadcasting and Mutual networks for broadcasting a session of the House of Delegates. This meeting was opened by the Speaker of the House, Dr. F. F. Borzell of Philadelphia, followed by addresses by Retiring President Dr. E. E. Irons of Chicago, and the Incoming President, Dr. Elmer L. Henderson of Louisville. It was the first time in the history of the Medical Association that such a broadcast was presented.

Two other important activities occurred, one was the selection by the House of Delegates of Dr. Evarts A. Graham, Professor of Surgery, Washington University, St. Louis, Missouri, to receive the Distinguished Service Award medal. The other was an announcement by the President of the Board of Trustees to carry on an intensive educational campaign beginning October, 1950.

The House of Delegates was informed before the San Francisco convention adjourned that the Interim Session as originally planned for Denver, Colorado, would not be held there but would be held in Cleveland, Ohio, December 5-8, 1950.

The other major activities were the scientific sessions and the technical exhibits. Scientific program was well attended by a large number of physicians. Many interesting papers were read and discussed. It might be added here that your Illinois delegates, as all State delegates, are denied the privilege and opportunity of attending much of the scientific session, because of their required attendance at the House meetings. The technical exhibits are always interesting and drew capacity crowds. Here is shown the new progress in drugs and their use in medicine and surgery; also all new appliances and equipment for use by physicians and hospitals.

REPORT ON THE CLEVELAND INTERIM OR CLINICAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION

This was the fourth clinical session of the American Medical Association and was held in Cleveland, Ohio, December 5th thru the 8th, 1950. Something like 2,500 Fellows of the American Medical Association registered for this meeting. This with the interns, residents and members of allied professional groups plus exhibitors swelled the general attendance to perhaps 6,000 people.

There was some discussion as to whether or not this interim or clinical session should be continued. However, it was decided it should be continued on for some time, consequently the 1951 session was scheduled for Houston, Texas, and the 1952 session will be held in Denver.

The House of Delegates held its first meeting on Tuesday morning, December 5th. Out of a total of 198 members of the House, 195 were registered for the meeting, this is an all-time record. It might be stated here that all Illinois delegates attended all sessions of the House at both the San Francisco meeting and the Interim Session at Cleveland. Every delegate is required to sign an attendance slip for all sessions. This includes morning and afternoon sessions of each day's meeting.

Four of your Illinois delegates were selected as members of reference committees, Dr. Bernard Klein of Joliet being Chairman of "The Committee on Sections and Section Work."

The House continued in session all day Tuesday. Speeches were made by the President, and Chairman of the Board of Trustees, Dr. L. H. Bauer. He reported an increase in membership and fellowships during the current year. It was Dr. Bauer who asked the opinion of the House on continuance of the Interim Session. He reported a profit from the first clinical session which was held in Cleveland and then a loss in the second and third conferences which were held in St. Louis and Washington, respectively. Dr. Bauer stressed the point that this loss was not a principal factor, that the American Medical Association wished to have the sessions for the benefit of the general practitioners.

Dr. Bauer at a later session told of the American Medical Association Board being responsible for the development of a special committee to solicit funds for medical schools needing financial assistance. He reported that the A.M.A. was making an appropriation of one-half million dollars to start this fund and that other funds would be solicited from physicians, supply houses and other sources. It was stressed that the profession did not desire federal aid for medical education as it was brought out that if the federal government gives financial support it would naturally expect to supervise the expenditures. In this connection federal control of medical education is not desirable.

Many resolutions were introduced by the House and passed on at their later sessions. At the first session of the House on Tuesday morning the outstanding general practitioner was selected; this man was Dr. Dean S. Luce of Canton, Massachusetts.

The Committee on Blood Banks gave an interesting report, Committee recommended that every State Society develop its own blood bank Committee to cooperate with the American Medical Association and to make a survey of blood banks within their States.

On Thursday the House of Delegates was treated to an unexpected and very favorable program. This was an address made by a representative of a large A. F. of L. labor union. This address entitled "How Socialized Medicine is No Bargain" was prepared by Mr. William L. Hutcheson, General President, United Brotherhood of Carpenters and Joiners of America and Vice President of the American Federation of Labor. Due to illness Mr. Hutcheson was not able to be present so his assistant, Mr. Peter E. Terzick, Editor of "The Carpenter" read the address. This union has about 700,000 members and this event probably marks the beginning of better relations between the medical profession and labor groups.

The House of Delegates before adjournment from the Cleveland Session approved the meetings set up for the next three years. It was the general consensus that the Clinical or Winter Sessions should be continued.

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Respectfully submitted, WILLIS I. LEWIS, M.D., WARREN W. FUREY, M.D., CHARLES H. PHIFER, M.D., ROBERT H. HAYES, M.D., FRED H. MULLER, M.D., BERNARD KLEIN, M.D., MATHER PFEIFFENBERGER, M.D., HARLAN ENGLISH, M.D., EVERETT P. COLEMAN, M.D., G. HENRY MUNDT, M.D., *Delegates to the A.M.A.*

REPORTS OF COUNCIL COMMITTEES

ADVISORY COMMITTEE ON FETUS AND NEWBORN

The Advisory Committee on Fetus and Newborn was appointed during the Pediatric Survey in Illinois. The Advisory Committee has not had any call for activity during the past fiscal year. There have been no meetings, no resolutions passed, and the Committee has no recommendations to make to the House of Delegates.

Respectfully submitted, GERARD N. KROST, M.D., *Chairman,* PHILIP L. ARIES, M.D., H. N. SANFORD, M.D., IWAN ROSENSTERN, M.D., GERALD M. CLINE, M.D., JOHN R. VONACHEN, M.D., HOMER F. WEIR, M.D., JAMES B. GILLESPIE, M.D., WALTER M. WHITAKER, M.D., *Advisory Committee on Fetus and Newborn.*

ADVISORY COMMITTEE ON VENEREAL DISEASE CONTROL

There has been no meeting of the Committee as a whole during the past year as there has been no special indication for same. Your Chairman has been in close contact with Leonard M. Schuman, M.D., chief of the Venereal Disease Control of the State Department of Public Health.

I am pleased to submit this factual resume of the activities of last year with an appraisal of the VD problem and the improved methods used to combat same.

This report in summary consists of two tables, one dealing with morbidity reporting for the calendar year 1950 as compared with the corresponding period of 1949, as well as a table on rapid treatment facility admissions of downstate Illinois patients for the calendar year 1950 as compared to the preceding year.

It will be noted from Table I that there has been a decrease of 16.7% in reported cases of venereal disease in 1950 as compared to 1949. Similar decline in private physician reporting is noted during 1950; syphilis reporting decreasing 16.7% and gonorrhea decreasing 32.2%. The ratio of early syphilis (primary, secondary, early latent) reporting to all syphilis reports for both private physicians and other agencies has slightly decreased in this past year with a percentage of 41.8% for 1950 as compared with 47.6% for 1949. A similar relationship for private physician reporting indicates that 40.3% of all syphilis cases were infectious or potentially infectious in 1950 as compared to 42.6% in 1949.

Table II which deals with downstate Illinois cases admitted to rapid treatment facilities at State expense, shows that the total admission loads have fallen from the previous year's level. This was due primarily to the increasing use of penicillin by private physicians and other reporting agencies in the ambulant therapy of syphilis patients. It is still estimated that approximately 50% of all admissions to all facilities were referred by private physicians.

For the fiscal year 1950, 91 treatments given by private physicians were at State expense as compared to 212 in fiscal 1949. This was for patients who lived in areas inaccessible to clinics where they would have received indigent care and who could not be hospitalized for various reasons.

The increase in distribution of drugs to private physicians noted in fiscal 1949 has continued in the fiscal year 1950. Penicillin distribution to private physicians has increased considerably in this fiscal year, with a decrease in the distribution of arsenicals and heavy metals. Whereas in the preceding fiscal year over 39 billion units of penicillin were distributed to private physicians, public clinics, hospitals and institutions and rapid treatment centers, in fiscal 1950 there was a further increase of 53% for a total of 61 billion units.

Procaine penicillin, which had been previously distributed to private physicians and other reporting agencies, upon request, for the treatment of cases of early syphilis, syphilitic pregnancies, congenital syphilis (under ten years of age) and asymptomatic neurosyphilis, was made available to reporting agencies this fiscal year for the treatment of all stages of syphilis.

Contact investigations by the Illinois Department of Public Health have continued to show improvement for this period over the preceding fiscal year. Not only was there an improvement in the percentage of contacts examined (3.2%) but also in the percentage of contacts found to be infected (4.4%) and that of infected contacts who were treated (3.1%). The improvement (4.0%) in the examination of contacts elicited from patients of private physicians contributed to this overall improvement.

In line with the reduction in total number of early infectious and potentially infectious syphilis cases and gonorrhea cases reported, there was a similar decline in the total number of contact referrals and investigations. Thus, a reduction in quantity of contact investigations was accompanied by an improvement in quality.

In-service training for personnel of this Division and in the field is an important part of our educational activity. As opportunities arise, the Division recommends that clinicians, nurses and investigators be given the advantage of attending venereal disease courses in various institutions. In this fiscal year, in-service training at the Chicago Intensive Treatment Center and the St. Louis Midwestern Medical Center, for staff and supervising nurses from Illinois Health Departments, have continued in popularity. In 1950, 40 nurses availed themselves of this two week course in venereal disease nursing technics, diagnostic procedures and follow-up of rapid treatment cases. Clinicians and health officers are given the opportunity to attend courses at the U. S. Public Health Service Hospital in Hot Springs, Arkansas, on venereal disease control which includes diagnostic procedures, technics of treatment and general control methods. In this year, 5 clinicians and 1 health officer attended this course.

A case-finding educational program was initiated in East St. Louis with the cooperation of the U. S. Public Health Service and the East St. Louis City Health Department. This project was developed for the purpose of finding new cases of venereal disease through the education of the public recognizing or suspecting the early signs and symptoms of syphilis . Publicity used to familiarize the population with the venereal disease problem included radio broadcasts, newspaper releases trade pamphlets, lavatory signs, match books, movies and educational materials.

Another venereal disease educational project included 8 venereal disease tent shows at county and state fairs during the summer of 1950. The attendance at these Fair Tent Shows amounted to 56,150 individuals.

In Table I a comparison of venereal disease reporting for 1949 and 1950 by all reporting sources and private physicians has been made.

32,804 cases of venereal disease were reported to the Illinois Department of Public Health in 1950 as compared to 39,404 in 1949, a decrease of 16.7%. Significant decreases in 1950 were apparent for syphilis (19.0%), gonorrhea (16.1%), lymphogranuloma venereum (31.8%) and granuloma inguinale (25.6%). An increase of 54.4 per cent was apparent in chancroid in 1950.

A sharp decline (29.0%) in the reporting of primary, secondary and early latent cases of syphilis is noted in 1950. This is significant in light of the fact that there has been increasing trend in the reporting of late and late latent cases of syphilis. A moderate decline is noted for gonorrhea in 1950, although the number of cases (21,037) represents a high level of reporting in Illinois for this disease.

The overall decrease in reporting of venereal disease by private physicians in 1950 as compared to 1949 was 23.1 per cent. Syphilis cases reported by private physicians in 1950 (5,143) and gonorrhea cases (2,922) represented sharp decreases from the syphilis and gonorrhea figures in 1949; these differences were 16.7% for syphilis and 32.2% for gonorrhea. In 1949, 42.6% of all syphilis cases reported by private physicians were in the infectious and potentially infectious stages; however, in 1950 this percentage decreased to 40.3%, a statistically insignificant diminution in early syphilis case-finding.

The rapid treatment program of the Illinois Department of Public Health, utilizing private hospital facilities on a per diem basis, has continued in operation in 1950. Besides agreements with 20 private hospitals in downstate Illinois, downstate patients have access to the two rapid treatment centers in Chicago and St. Louis. A special study of ambulant therapy, which was developed in 1947 in three large health department centers, has been enlarged to include all the clinics in downstate Illinois in 1950. Private physicians and venereal disease clinics may refer cases of early syphilis, congenital syphilis and syphilitic pregnancies, as well as asymptomatic neurosyphilis, to those institutions for rapid treatment at State expense.

Table II presents a comparison between the year 1949 and 1950 of the number of downstate Illinois cases admitted to rapid treatment facilities. Total admissions in these facilities decreased in 1950 by 9.6 per cent. Although percentage decreases in admissions were apparent for the downstate hospital facilities (42.9%), the Chicago Intensive Treatment Center (59.0%) and the St. Louis Midwestern Medical Center (32.9%, a

TABLE I.

REPORTING OF VENEREAL DISEASES BY ALL SOURCES AND BY PRIVATE PHYSICIANS
ILLINOIS — CALENDAR YEARS — 1949-1950

DISEASE AND STAGE	*NUMBER OF CASES REPORTED*			
	TOTAL CASES		*PRIVATE PHYSICIANS*	
	1950	1949	1950	1949
SYPHILIS	11,264	13,904	5,143	6,176
Primary and Secondary	1,569	2,610	723	1,028
Early Latent	3,137	4,015	1,350	1,605
Late and Late Latent	6,145	6,836	2,892	3,356
Congentital	413	443	178	187
GONORRHEA	21,037	25,080	2,922	4,309
CHANCROID	383	248	9	10
LYMPHOGRANULOMA VENEREUM	88	129	2	8
GRANULOMA INGUINALE	32	43	4	3
TOTAL VENEREAL DISEASES	32,804	39,404	8,080	10,506

TABLE II.

DOWNSTATE ILLINOIS CASES ADMITTED TO RAPID TREATMENT FACILITIES FOR THE CALENDER YEARS 1949-1950

Rapid Treatment Facilities	Period	Total Admissions	SYPHILIS					GONORRHEA	OTHER V-D
			Primary and Secondary	Early Latent	Late and Late Latent	Congenital	Central Nervous System		
Downstate Illinois	Jan. to Dec. 1949	455	193	179	21	22	40	—	—
Hospital Facilities	Jan. to Dec. 1950	260	102	104	15	16	23	—	—
Downstate Illinois									
Clinic Ambulant	Jan. to Dec. 1949	171	91	45	17	7	11	—	—
Therapy	Jan. to Dec. 1950	515	135	159	166	23	32	—	—
Chicago Intensive	Jan. to Dec. 1949	229	57	71	22	19	55	1	4
Treatment Center	Jan. to Dec. 1950	94	22	15	10	11	35	—	1
St. Louis Midwestern	Jan. to Dec. 1949	413	153	100	56	18	71	10	5
Medical Center	Jan. to Dec. 1950	277	62	82	52	19	54	4	4
All Treatment Facilities	Jan. to Dec. 1949	1268	494	395	116	66	177	11	9
	Jan. to Dec. 1950	1146	321	360	243	69	144	4	5

large increase (201.2%) in admission was noted for the downstate Illinois clinic ambulant therapy program. Early syphilis admissions to rapid treament facilities in 1950 declined in number by 23.4%, congenital syphilis by 4.3% and central nervous system syphilis by 18.6 per cent.

Respectfully submitted, I. H. NEECE, M. D., *Chairman,* NORRIS J. HECKEL, M. D., HARRY J. DOOLEY, M. D., FRANK M. HUFF, M. D., J. E. WHEELER, M. D., *Advisory Committee on Venereal Disease Control.*

ADVISORY COMMITTEE TO VETERANS ADMINISTRATION

The system of home-town medical care for veterans, established three years ago by contract between the Illinois State Medical Society and the Veterans' Administration, continued to work out satisfactorily during the last year. That was due in no small measure to the sympathetic understanding of our problems and the fine cooperation of Dr. B. A. Cockrell, chief medical officer in the Chicago Regional office of the Veterans' Administration, and the committee desires to express formally in this report its continuing satisfaction with Dr. Cockrell's services and his willingness to work whole-heartedly with us for the benefit of the veterans who receive this care.

At the same time, Dr. Cockrell, in a recent letter summing up the results of the year's work, added these words of appreciation to the Society and its members who provided the services:

"Your continued co-operation and the success with which the program has been carried on to date have been most excellent."

The following paragraphs outline the most important developments of the year in this program.

Fee Schedule Increases. The Veterans' Administration early this year amended the fee schedule adopted Aug. 12, 1948, to increase the allowances in five categories as follows:

Pneumoencephalography, including operative preparation but excluding X-ray fee	$15.00	$25.00
Ventriculography, including operative preparation but excluding X-ray fee	50.00	75.00
Bronchoscopy, without biopsy	25.00	30.00
Bronchoscopy, with biopsy	35.00	40.00
Esophagoscopy, with removal of foreign body	30.00	50.00-100.00

Suggested Improvements. Paper work is never welcomed by physicians, but no program of this size can be carried out successfully without some, and it is the opinion of this committee that the red tape involved in this program has been kept to a minimum. However, Dr. Cockrell reports some difficulty in getting a few of our members to observe the requirement that requests for authority to treat established patients be sent in at the end of each month for the following month. When such requests are not received until well after the first of the month, difficulty arises, for such authority can be granted under the rules only for treatments to be given after receipt of the request.

The committee therefore urges all members participating in this program to be more prompt in forwarding such requests for authority at the proper time.

Prescriptions. Dr. Cockrell has also forwarded to this committee a copy of a letter from Dr. Arden Freer, acting chief medical director, department of medicine and surgery, Veterans' Administration, Washington, to Veterans' Administration offices and administrators throughout the country.

The letter, dated Feb. 27, 1951, comments on "certain unjustifiable prescribing practices" found in the Home-

Town medical program. These practices, briefly, are of three types: 1. Prescription of excessive quantities of medication; 2. Prescription of a disproportionately large number of injectable products; 3. Prescription of medication not indicated for the service-connected or adjunct condition for which the records show the patient is being treated. These are all self-explanatory. The letter notes:

"The above violations of law and the apparent disregard for sound medical ethics jeopardize the entire outpatient care program through fee-basis physicians."

Chief medical officers are directed to notify the state medical society when such practices are discovered with a request that it notify the offending physician in writing that repetition will result in his removal from the list of eligible physicians.

There is no iindication as to how much such practices are prevalent in Illinois, if at all, and the matter is recorded here at part of this report at the request of the Veterans' Administration. No specific instances of such abuses have yet been called to our attention for action.

Statistics. Dr. Cockrell has supplied us with the following interesting statistics for the year 1950 on the quantity and cost of care supplied to veterans of Illinois, not only under the home-town fee basis system, but also by physicians in the regional office in Chicago and in the offices at Champaign, Springfield, East St. Louis and Gary, Ind. To obtain the Illinois total, about 20 per cent should be deducted for the Gary, Ind., office.

Veterans Examined	
Regional Office	46,061
V. A. Offices	12,939
Fee Basis Physicians	6,037
Total	65,037
Veterans Treated	
Regional Office	23,094
V. A. Offices	5,630
Fee Basis Physicians	7,293
Total	36,017
Examinations Given	
Regional Office	161,984
V. A. Offices	42,759
Fee Basis Physicians	10,213
Total	214,956
Treatments Given	
Regional Office	52,818
V. A. Offices	9,553
Fee Basis Physicians	24,088
Total	86,459
Paid to Fee-Basis Physicians:	
For Examinations	$ 79,351.00
For Treatments	97,916.02
Total	$177,267.02

The personnel of the medical division in the Chicago Regional Office was reduced March 1, 1950, from 601 to 488, including both professional and clerical personnel. This was due principally to reductions in the budget and in part to a small falling-off in requests for services.

Respectfully submitted, PERCY E. HOPKINS, M.D., *Chairman,* F. LEE STONE, M.D., *Vice-Chairman,* HARRY M. HEDGE, M.D., HAROLD M. CAMP, M.D., *Advisory Committee to Veterans' Administration.*

ADVISORY COMMITTEE TO THE IPAC

Because of the fact that this Advisory Committee has been functioning for the past ten years and because many of the younger members of the Society have not had an opportunity to know the background of the committee's work, it seems advisable to preface this report with a brief history of what has gone on in the past to make it easier to realize the problems of the present.

Prior to the past ten years when the type of individual who became unable to work because of age, or other disability and was in the category of what is now termed "wards of the state" became in need of medical care it had to be furnished by his relatives, many of whom were unwilling or unequal to this task, or an order was furnished by the supervisor, or more commonly the doctor rendered the service and received no pay whatsoever. In areas where supervisors accepted their responsibility for this type of individual a survey ten years ago indicated that in two counties of the state the supervisors paid the regular fee. In practically all other areas of the state, if the supervisor paid the fee at all, and he might have taken care of the patient's hospital bill and paid the doctor nothing, he paid a small amount to the hospital, much less than the cost to the hospital for keeping the patient, and allowed the doctor very little for home and office calls and no additional allowance for drugs. Quite commonly the amount allowed for major surgery was $25.00 and this was not granted in many instances.

When this committee was formed under the chairmanship of Dr. Charles H. Phifer it had to do all the pioneer work because nothing similar had been done in any part of the country. The Public Aid Commission was then under the direction of the Department of Public Assistance, which had its chief interest in the management of insane asylums. The doctor had to furnish reports each month in quadruplicate on each patient and the original fees were $1.00 for office calls, $1.50 for house calls and a maximum of $50.00 for major surgery. After the first four years, during which time the committee went through the tedious and difficult task of getting the red tape reduced from four copies to one relatively simple bill form for rendering statements of account, the work was transferred to the Illinois Public Aid Commission which was made a separate division and separated entirely from the Department of Public Welfare.

Following this separation our problems were somewhat simplified and year by year we were able to make moderate or slight, but consistent advances in the simplification of the work, in expanding the program, and in a gradual increase of fees as the cost of living also rose. Last year we had fully expected to have an in-

crease in the fee bill but unfortunately the legislature saw fit to cut the appropriation by $18,000,000.00 This made any increases utterly impossible and the budget was trimmed every way it could be with the exception of the medical fees. We felt we were fortunate to prevent any reduction in these.

During the past year the committee has met with the commission at regular intervals, usually once a month, and any urgent business to be transacted has been done by mail with the various members of the committee, so that problems which arise frequently in this type of work are usually settled with a minimum of delay. The following problems have occurred:—the question of recipients of Public Aid services abusing their privileges. This has sometimes been a definite medical problem but has usually been handled to a fair degree of satisfaction because of the excellent cooperation between the local County Advisory Committees and the Public Aid Commission. Another problem has been that of excessive care, or making charges beyond those allowed by the commission for the type of service that was rendered. Since this involves the use of federal funds there have been some occasions when federal departments have entered the picture and have preferred charges against some of our members. Fortunately these have been few and in most cases we have been able to protect the interests of our members when we felt the errors were simply of judgment and not of intent. In some instances the federal investigations have gone on in spite of or over our objections but in the majority of instances the advice of the committee has been accepted and we have been able to render our members substantial protection. Our relations with the Illinois Public Aid Commission have been exceptionally satisfactory.

As time goes on there has been an increasing demand on the part of the doctors for an upward revision of the fee schedule and with this the committee has been in hearty accord. However, with the biennium budget running so far behind that the legislature recently had to appropriate a deficiency fund to make up the deficit, it was impossible to do anything in this respect until such time as the new budget has been approved. At the time of this writing the Public Aid Commission has submitted to the legislature its estimated needs for the coming biennium. It is now in the process of discussion and a definite answer has not as yet been returned. It is therefore impossible for the committee and the commission to get together on any fee bill. However it is hoped that before the House of Delegates is in session we will have definite information and be able, in the form of a supplementary report, to let the House know what the prospects are for the coming two years.

An additional problem has been that of Public Assistance recipients receiving pay for the physician's services and then using it for other purposes so that the doctor was not paid for work he had done. The degree of this seems to vary in different sections of the state, but it is enough to be a problem in many places. There are many physicians who prefer to continue in the present method of having the funds paid to the recipient who in turn pays the physician, but there is an increasing number, and now I believe a decided majority, who are very much in favor of direct payment. This will bring about new complications which we may not fully appreciate at the present time, but it is undoubtedly the wish of the profession that this be done. Therefore the committee has worked with the commission for the past three years and finally the new social security act recently passed in Washington authorized direct payments to the physician for services rendered to Public Assistance recipients. When this occurred we were quite certain that it would be in effect in Illinois by the first of last November. The department was already to institute this type of procedure and had its plans ready to put it into effect. However, the plans had to be approved by the Federal Security Agency in Washington and with true bureaucratic methods, they have demanded changes in the Illinois law and the setting up of a separate fund before they will approve anything of this sort. As a result the commission has been unable to authorize direct payment until a new bill has become a law. This bill has already been introduced into the legislature in Springfield with the request that, as it is urgent, it be passed as quickly as possible. Again it will take a period of a few weeks before an answer can be given as to whether or not such act has become a law and as to when direct payment can be put into effect. We hope also to make a separate report at the meeting of the House of Delegates to this effect.

Federal legislation which has to do with Public Assistance recipients in Illinois can be listed under the Federal Social Security Act Amendments as enacted into public law No. 374. The two amendments which most closely concern the medical profession are those relating to the Disability Assistance program and to the provision which now permits Federal matching of payments made directly to the source of medical care. The Disability Assistance program became effective in Illinois in November, 1950 and is being operated on the basis of the Public Assistance code which permits the Illinois Public Aid Commission to cooperate with the federal government and any federally aided program of Public Assistance. The attorney general of Illinois in a formal opinion advised that the commission could operate the Disability Assistance program under these broad powers and the general assistance funds might be used for the state's share of assistance given in this program. The opinion further stated that the commission has this authority pending action by the General Assembly. There is now a bill pending in the legislature setting up the Disability Assistance program. This first bill may have to have certain amendments before it can fit in with the Federal Social Security Act. In the Disability Assistance program, it is entirely different from the controversial disability insurance program which was defeated in Congress and did not become a part of HR-6000 which so many of you sent in resolutions against from your local communities. It is a further act by which the unemployables are taken away from the supervisors assistance program and put under the state assistance program. It is not required that these people be given medical assistance under this program and our only responsibility is that of an ex-

amination to determine whether or not they are permanently and totally disabled. As a general rule the County Medical Advisory Committees have been in charge of this part of the program and have been handling it to a very satisfactory degree. The new federal law permits federal participation in both cash assistance and direct medical payment up to the usual ceilings which govern federal participation, that is, $50.00 per month in Old Age Pension, Blind Assistance and Disability Assistance and $27.00 per month each for the mother and first child and $18.00 per each additional child in the Aid to Dependent Children program. The federal requirements in this latter program are so complex that they are difficult to administer but the plan which has now been approved is to set up a per capita amount for medical care each month for each person on the Public Assistance roll. This might be compared to an insurance fund from which the commission can make direct payments for medical care. In order to have authority to do this to meet federal requirements state legislation is still necessary and a bill has now been introduced which will make this possible. An additional complication on the basis of recent federal legislation is in the examination of the Blind Assistance recipients to determine whether or not they come under the meaning of the act. The ruling to date has been that an ophthalmologist must make this examination. However the new law makes it mandatory for all states to permit the applicant to have a choice of a physician or an optometrist as of July 1, 1952. It is hoped to have the Illinois law amended so that if the federal law is amended we will not need to have examinations done by optometrists.

At a recent meeting with the commission the following steps were brought up in reference to an increase in fees: first, a formal request was made for an increase in the fee bill under the Public Aid Commission services; second, the commission has discussed this informally and agreed as to the need; third, the commission included in its appropriation request, funds for such an increase; fourth, the commission is unable to take formal action until the funds are actually available but as stated before, your committee hopes to be able to make in the form of a supplementary report, more specific information as to what can be done with this request for an increase in fees.

The committee feels that we can safely say our relationship with the Department of Public Assistance has been very satisfactory, that we have obtained excellent cooperation, and that the Public Assistance recipients are receiving an excellent degree of medical care.

In conclusion your committee feels that we have finished a ten year period during which time we have improved our relationships with the department and have also continued the improvement of medical care to Public Assistance recipients. We feel that next year the advances which are in prospect at the present time will still further improve the relationship between the physician, the commission, and the Public Assistance recipient.

The accompanying statistics for the past year may be of interest.

Respectfully submitted, EVERETT P. COLEMAN, M. D., *Chairman.* EDWIN S. HAMILTON, M. D., JULIUS H. HESS, M. D., HARLAN ENGLISH, M. D., B. E. MONTGOMERY, M. D., THEODORE R. VAN DELLEN, M. D., *Advisory Committee to Illinois Public Aid Commission.*

ILLINOIS PUBLIC AID COMMISSION

Cost of Medical Assistance

January through December, 1950

	ADC	BA	OAP
	Medical Care		
Total	$1,038,840.83	$187,369.74	$5,934,724.84
Physicians' Services	437,663.94	82,249.34	2,700,901.22
Dental Care	91,147.70	5,345.61	96,912.85
Hospital Care	358,856.99	54,725.02	2,182,511.28
Nursing & Housekeeping Care[1]	35,619.73	34,367.16	590,046.42
Ocular Care. (Examination and glasses)	26,709.76	1,658.46	80,989.50
Other[2]	88,842.71	9,024.15	183,363.57
	Nursing Home Care		
Total	$ 454.08	$163,154.05	$5,784,355.11

Physicians' services averaged $225,000.00 per month.

[1]Nursing and housekeeping care in the patient's own home.

[2]Includes appliances, transportation, laboratory services, etc.

DR. E. P. COLEMAN: I wish to make the following supplementary report: When the Committee submitted its regular report, it called attention to the fact that two important items could not be included because of delays due to pending legislation in Springfield. Things have progressed to a point where the probable outcome of such legislation can be estimated.

You are aware from previous reports that the problem of direct payment for services rendered public assistance recipients was impossible because of bureaucratic regulations in Washington. While many doctors felt that direct payment has many potential dangers and are opposed to it in principle, there is an increasing number who are asking for it. During the past two or three years the demand for direct payment has increased steadily on the part of the doctors. Therefore, your committee has tried to get this accomplished by working through the Illinois Public Aid Commission. The Commission has been very cooperative with the Medical Society and was largely instrumental in obtaining an amendment to the Social Security Act last fall, making this possible. We then hoped for direct payment as of last November. However, it was found that Federal Accounting requirements are such that direct payment cannot be accomplished administratively without setting up a separate fund, and this fund cannot be established and meet federal requirements without special legislation.

S.B. 618 has been introduced by Senator Korshak and referred to the Committee on Public Health and Welfare. The purpose of this bill is that of setting up a trust fund to carry out the plans of direct payment. If this bill passes, direct payment will be put into effect for the August or September medical bills, as soon as the necessary records can be made available. The commission is hoping to keep the forms simplified in spite of federal participation in this fund. At the start, it will probably be necessary to have recipients sign a blank acknowledging receipt of services, this being a federal requirement. The Committee hopes to get this requirement eliminated as soon as possible. Incidentally the state Dental Society also went on record one or two weeks ago as asking for direct payment for their services also.

The second item which we were unable to list in the regular report has to do with proposed changes in the fee schedule.

From the very beginning your Committee has been able to effect improvements in the fee bill and to minimize paper work as the program has developed until last year. At this time due to a legislative reduction in the appropriation an increase in fees was impossible due to lack of available funds. During the past two years the Committee has called the Commission's attention on many occasions to the need for an upward revision of fees, and the Commission has acknowledged the justification for this revision.

The new appropriation bill S.B. 556 introduced May 8th was at first recommended to pass by the Senate Committee, but was recalled until the disability bill is passed and until other requests can be incorporated such as that of the funeral directors who also want an increase. If the appropriation bill passes without too much change funds for increase in fees will be available. With this probability in mind the Public Aid Commission after three special meetings with your Committee, completed a tentative agreement last night for the following changes in the fee bill:

Some of these revisions went through without argument, and some were the result of necessary compromise. The changes are as follows:

	From	To
Office visit	$ 1.50	$ 2.00
Home visit		
(day)	2.00	3.00
(night)	3.00	4.00
Hospital visit	2.00	2.00
Minor surgery	5.00-25.00	5.00-25.00
Major surgery		
ordinary	75.00	100.00
complicated	100.00	125.00
Examinations		
ADC and DA	5.00	7.50
Mileage	.25	.35-.50
Tonsillectomy and		
Adnoidectomy	35.00	35.00
Obstetrics	35.00	50.00 (plus $15.00) Complications

ADVISORY COMMITTEE TO THE UNITED MINE WORKERS

Last year when this committee reported to the House of Delegates the Medical, Health and Hospital Program of the U.M.W.A. Welfare and Retirement Fund was in suspension. This suspension period was in effect from September 17, 1949 up to and including June 30, 1950. On July 1, 1950 the Fund resumed its Medical, Health and Hospital Care Program by authorizing practically all necessary hospitalization and hospitalized medical care for all U.M.W.A. members connected with the coal industry, either working members, disabled members, or pensioned members together with their wives and dependent children under 18 years of age. The Fund did not provide for normal obstetrical care, routine tonsillectomies, the care of mental illnesses, dental care, ACTH or cortisone, nor for those cases where the employer or some other person was responsible for the provision of the necessary hospitalization. No home or office care was provided.

On September 28, 1950 the Trustees of the Fund authorized the extension of the program to provide the same services as outlined above to all unremarried widows of U.M.W.A. members and to the dependent children of the deceased miner. By November 1, 1950 this program was well in effect. The services of the Fund were also extended to provide a maximum of sixty days hospitalization per year for all bonafide dependents over 18 years of age of an eligible U.M.W.A. member who are totally dependent upon the member, have no income of their own, have been residing in the same home with the member for at least six months prior to their application. These dependents are listed on the member's eligibility form 85-HS with a star preceding their names.

On February 14, 1951 the Fund extended its services to provide all necessary hospitalization and hospitalized medical care for all obstetrical cases, normal and abnormal, and also to provide a limited amount of intensive treatment by psychiatrists or neuropsychiatrists in properly equipped hospitals for those mental cases that offer a reasonably good prognosis. Care for mental patients at the expense of the Fund can be provided only when specifically authorized by the Area Office; the authorization must be obtained in advance.

The U.M.W.A. Welfare and Retirement Fund is now providing practically all necessary hospitalization and hospitalized medical care for the U.M.W.A. workers and their dependents. The Fund has proceeded to expand its coverage cautiously and on the basis of practical experience. The Advisory Committee to the U.M.W.A. has held only three regularly scheduled committee meetings, due to the fact that the Fund was not in operation during the entire year. However the members of the committee have been in practically constant touch with the Area Medical Office and have given constructive assistance in the handling of relationships between the Fund and the medical profession in Illinois.

In the few instances where this became necessary the Advisory Committee has been able to handle to the

satisfaction of nearly all persons concerning the question of additions or deletions of the names of participating physicians and it appears that in the majority of the communities where miners constitute a high percentage of the population that the physicians who are caring for these medical care to the beneficiaries of this Fund and with the way the program is handled. There are exceptions to this statement but they appear to be decidedly in the minority.

The success of this program, as indicated by the Fund's ability to extend and expand its services, is due primarily to the cooperation extended to the Fund by the participating physicians and hospitals. The physicians, hospitals, and U.M.W.A. members, and the officials of the Fund have demonstrated that it is possible for this group to work together harmoniously and to the mutual advantage of all concerned. Problems have arisen in various sectors of the State as are to be expected, one problem being that the Veterans Fee Bill which has been the guiding principle of the charges for this type of work has not been increased with the increase of the cost of living. While other types of wage and income have increased, the physicians' charges to the members of the Fund have remained stationary. In addition, in some sections of the state where strip-mining is the major industry and where employment is continuous—in many cases being seven days a week—the incomes of these miners is such as to put them in a rather high income group as compared to employees of other organizations in these communities. Under these circumstances adhering to a routine fee bill which is rather low has caused some complaint and criticism. When it is considered, however, that the miners in many sections of the state only work three or four days a week and that the 25,000 U.M.W.A. working miners are caring for at least 20,000 retired or dependent miners and their families, and that many of these have been on relief or township care prior to the advent of this Fund into the communities, it is a practical certainty that the incomes of physicians practicing in the communities are of necessity higher than they would be with the Fund not in effect. Collection difficulties have been minimized and with increasing experience on both sides, the Fund seems to be serving a very practical purpose and doing it well.

Your committee feels that the administrators of the Fund have acted wisely when they started out for the second time, beginning last summer, in going cautiously and not over-reaching themselves in trying to do too comprehensive a job as was done in the very beginning. While the committee feels that certain changes in the fee bill should be made and feels that they will be affected in the future it is no doubt better to increase the type of service rendered first and see what the Fund can properly furnish before any changes are put into effect. It is to be hoped that as the next year provides both the medical profession and the Fund with increasing experience that this experiment in labor and professional cooperation will be increasing in its effectiveness.

The committee feels that in one particular it has provided a worthwhile accomplishment in requesting that the local County Societies or groups of Societies appoint advisory committees to meet with the area medical administrator of the Fund when any problems have arisen. This has enabled local problems to be taken care of by local men because these problems vary so decidedly in the mining fields in varying sections of the state. We feel that while much more remains to be done, the accomplishments to date are worthwhile and may ultimately be of value as a guide in future relationships with other organizations along this line. While the Advisory Committee has no actual authority it does have the effect of moral suasion and it is far better from the standpoint of the profession to have medical service of this type on a basis where the profession itself is at least considered and its advice accepted whenever possible, rather than have it entirely in the hands of people who do not have a sufficient awareness of medical methods and procedure and would thereby increase the problems instead of controlling and diminishing them.

Respectfully submitted, E. P. COLEMAN, M.D., *Chairman,* G. C. OTRICH, M.D., CHARLES O. LANE, M.D., WILLIS I. LEWIS, M.D., B. E. MONTGOMERY, M.D., RALPH S. SABINE, M.D., W. A. MONAGHAN, M.D., *Advisory Committee to the U.M.W.A.*

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Woman's Auxiliary of the Illinois State Medical Society has had a most active year. It has been my observation that this organization is continually looking for new ways to help the Society.

They have presently organized 34 Auxiliary Societies out of our 90 county medical societies. In the unorganized societies, they have members-at-large in 21 counties. Of the county societies newly organized, Jefferson-Hamilton County has been organized with 25 members. Wayne County with 11 members. Champaign County with 81 members. Carroll County with 4 members-at-large. The organization of Kankakee County is incomplete, their charter still being open, awaiting acceptance of the By-Laws.

The Auxiliary has had an extensive educational program forming study groups on such subjects as "The Compulsory Health Insurance Scheme" and "Voluntary Prepayment Medical and Hospital Care Plans." They have acquired a speaking knowledge of these subjects as well as a reading knowledge.

Cook County, being the largest Auxiliary, has had a number of meetings with outstanding attendance records. For example, a public relations meeting titled, "Medicine in Public Affairs" attended by 700, "Civil Defense" attended by 150. A School Health Program and a most successful Nurse Recruitment Program was just held last month. The Auxiliary has donated $5,354 to the Benevolence Fund and has secured a goodly number of subscriptions to the magazine "Today's Health."

The Auxiliary continues to demonstrate that it is medicine's able assistant, always able and willing to help where the need is greatest.

Respectfully submitted, H. KENNETH SCATLIFF, M.D., *Chairman,* WALTER C. BORNEMEIER, M.D., E. G. BEATTY, M.D., C. PAUL WHITE, M.D., HAROLD M. CAMP, M.D., *Advisory Committee to The Woman's Auxiliary.*

THE SECRETARY: Last night I received here in the Hotel two checks from the Woman's Auxiliary totaling a little over $4,500 as their contribution for a year to our Benevolence Fund. I think some recognition should be taken by the House of their generosity.

THE PRESIDENT: I will entertain a motion that the Secretary send a letter of thanks to the Woman's Auxiliary.

DR. OSCAR HAWKINSON, Chicago: I would like to make that motion and to ask the Secretary to make the letter as flowery as he can. (Motion seconded by Dr. James S. Templeton, Pinckneyville, and carried unanimously).

COMMITTEE ON CANCER CONTROL

An enormous amount of money is spent annually in research in an effort to find effective methods and agents to control cancer. All these efforts result in discovery of many important facts from time to time, but tremendous strides will probably have to be made in our research discoveries before an actual cure for cancer can be expected.

The two most active State agencies conducting activities in the fight against cancer are the Illinois Division of the American Cancer Society and the Division of Cancer Control, Department of Public Health. Both of these agencies have planned and carried out very effective programs including financial aid for research, lay and professional education, support of detection centers and cancer clinics, financial aid for varied programs caring for cancer victims, and numerous other helpful activities.

Dr. John Rogers is the Executive Director of, and Mr. Edward Wilson, President of the Illinois Division of the American Cancer Society. Dr. Rogers has kindly furnished the data as listed below representing activities of the Division.

The program of professional education for the Illinois Division of the American Cancer Society has been continued with marked success. Two five-day refresher courses were held during 1950, attended by about 100 physicians, most of whom were from downstate. This program was conducted at the Northwestern University Medical School, the University of Illinois College of Medicine, the Loyola University School of Medicine (Mercy Hospital), the University of Chicago School of Medicine and Michael Reese Hospital. It is believed that this course is unique in the country since it provides expert instruction in the early diagnosis and treatment of cancer in every part of the body. These courses are sponsored in cooperation with the Illinois State Medical Society.

Research continues to be a major activity of the Society. Twenty-five per cent of all funds collected are automatically allocated for this purpose. The Society finances research in three ways—direct allocations to institutions, grants-in-aid to individual investigators, and training fellowships. During the past year, medical institutions in Illinois received $315,460 from the American Cancer Society for research on cancer. The Division continued support for seven diagnostic clinics and eight cancer clinics.

Grants were made by the Illinois Division of the American Cancer Society to fifteen Visiting Nurse Associations throughout the state during the year. This is on a cost per visit basis for cancer patients unable to pay for visiting nurse service. Outside of the Chicago area, 294 cancer patients received a total of 5818 calls. The Division continued support for the operation of cancer detection centers. Important grants in this category were Cancer Prevention Center of Chicago, Inc., Mercy Hospital and Grant Hospital. Last year, 7,373 persons were examined at these centers. It should be emphasized that no patients are treated in detection centers. When a diseased condition is found, the patient is sent back to his physician.

The Division recognizes that the cancer detection center is not the answer to the early detection of cancer in great masses of population. The Division has actively continued to support the program approved by the Council on January 16, 1949, best described by the slogan of the American Medical Association, "Every doctor's office a cancer detection center." Several additional county medical societies have approved the plan for a modified examination for early detetion of accessible cancer.

The Division distributed, free of charge to 3,250 Illinois physicians, a professional publication, The Cancer Bulletin (a special edition of the Texas Cancer Bulletin) containing latest professional information. This very fine bulletin, a startling development in medical reporting, has been very well received. Any Illinois physician will be put on the mailing list upon request.

A new cancer bulletin, "CA, A Bulletin of Cancer Progress," is now being published by the American Cancer Society. The first issue was distributed free of charge to the physicians on our mailing list. It is expected that both publications will be distributed throughout the year, although final decision has not yet been made.

Motion pictures have been made available employing both color and sound. Three films are available for loan to any medical society or hospital staff. They are titled, "Cancer: The Problem of Early Diagnosis," "Breast Cancer: The Problem of Early Diagnosis," and "Gastrointestinal Cancer: The Problem of Early Diagnosis." Twenty-five county medical societies reviewed the films and they were shown at staff meetings in many hospitals.

The mission of the Illinois Division is considered to be to assist the physician in every ethical way in the control of cancer within the state. Under the guidance and leadership of hundreds of physicians, the public education program is designed to substitute an intelligent concern regarding cancer instead of the unreasoning fear and superstition which is so prevalent. Hundreds of thousands of pieces of literature have been distributed. Educational films have been shown thou-

sands of times to many thousands of people. Industrial educational programs have been conducted with marked success. The educational exhibit at the Museum of Science and Industry in Chicago continues to be a focal point of interest to thousands of visitors. Since its opening in April, 1949, over 400,000 people have visited this educational exhibit.

During the latter part of the year, the American Cancer Society produced a film, "Breast Self-Examination," which has resulted in an unprecedented demand for showings to female groups. It is based on the fact that any woman herself may discover the early painless lump of breast cancer at a time when the chance of cure is 90% favorable. An outstanding example of effective public education is the purchase of several copies of the film by the Illinois Bell Telephone Company for a systematic showing to over 24,000 female employees. The possibilities of this program in the reduction of mortality from breast cancer are evident.

Volunteers of the Society made and distributed 350,000 cancer dressings throughout the year. These are available to any cancer patient upon request. Sixteen loan and gift closets have been established which have provided equipment for 238 cancer patients in their homes.

The active participation of the nursing profession is essential to the success of the cancer control program. To stimulate and prepare the nurses of Illinois to participate, the Illinois Division has lent the film, "What is Cancer?" and provided educational materials to 45 schools of nursing. Seventy-five groups of graduates have also seen the movie. Guidance has been given to many industrial nurses in conducting employee education on the job. Talks have been given by members of our staff to many nursing groups, including the entire nursing staff of the Chicago Department of Health. Realizing the great need for adequate training of practical nurses, a grant of $500 was made to assist with the training of these women and help given in preparing them to participate in the cancer control program."

Dr. G. Howard Gowen is Chief of the Division of Cancer Control of the Department of Public Health for Illinois. He has kindly submitted data given below, representing a summary of their activities:

There are now twenty-five cancer clinics in Illinois receiving financial and other assistance from the Illinois State Department of Public Health. The Clinics located in Rockford, Herrin and Savanna used twelve teaching consultants during the year for professional education.

Five of the local health officers were sent to attend the cancer refresher course in Chicago sponsored jointly by the Illinois Division of the American Cancer Society and the Illinois State Medical Society. Also one of the local health officers was sent to attend a refresher course on cancer and heart disease held at the School of Public Health, University of Michigan. Two pathologists were sent to take the course in exfoliative cytology given at Cornell University Medical School under the supervision of Dr. Papanicolaou. The gynecological consultant at one of the cancer clinics was sent to take a special course relating to carcinoma in situ of the cervix, at Washington University.

In the spring of 1950, the State Department of Public Health began the distribution through the cancer clinics of testosterone and stilbestrol for use by physicians on inoperable cases of cancer of the breast. Over a period of approximately eight months steroid hormones were provided for 41 patients. This service, of course, was only for patients in poor financial circumstances.

During the past year the Illinois Dental Society in cooperation with the Bureau of Public Health Dentistry set up a dental caravan which held meetings in the cities of Belleville, Decatur, Sterling, LaSalle, Quincy, and Bloomington. Part of each meeting was devoted to the subject of oral cancer and the Illinois State Department of Public Health provided the services of a pathologist from the nearest cancer clinic in each instance who demonstrated various oral lesions and the method of taking biopsies in the oral cavity. These meetings were very well attended and the subject matter was very enthusiastically received.

The Department of Public Health finished the second study of the value of the tuberculosis chest survey as a means of screening for early malignancies of the lung and a report was presented at the annual meeting of the American Public Health Association in St. Louis.

In cooperation with the Cancer Committee of the Illinois State Medical Society, the State Department of Public Health set up and introduced to the medical profession of Illinois the use of a cancer verbal screening form, which consists of several questions relative to some of the more common symptoms of cancer. It is hoped that these forms can be filled out by patients, and early cases of cancer found which otherwise might not be detected for months. By the end of 1951 information will be available on how enthusiastically this was received and what beneficial results occurred.

A copy of the publication "Cancer Manual for Practitioners, prepared by the Massachusetts Division of the American Cancer Society, was sent to all doctors of cancer clinics and all health officers.

Respectfully submitted, WARREN H. COLE, M. D., *Chairman.* ROSWELL T. PETTIT, M. D., LEO J. BROWN, M. D., THOMAS C. GALLOWAY, M. D., EDWIN F. HIRSCH, M. D., JOSEPH H. LUNDHOLM, M. D., *Committee on Cancer Control.*

COMMITTEE ON CONSTITUTION AND BY-LAWS

Study of problems relating to membership diffculties in the Illinois State Medical Society has been made. The following changes in the Constitution have been drawn up by the Committee and are recommended for favorable consideration:

Amend Article IV, Section 3, Emeritus Members, by deleting the word "and" after thirty-five years and substituting the words "or who," therein. The amended section will then read, "A member who has been in good standing for thirty-five years or who has reached the age of seventy, may, on recommendation of his component society, be made an Emeritus Member, and have all the rights and privileges of membership with-

out payment of dues to the component or State Society."

Amend Article IV by changing Section 7 to Section 8 and Section 8 to Section 9.

Amend Article IV by adding a new Section 7. Retired Members. Members of the Society, who by reason of age or mental or physical incapacity have retired from active practice, may on request of the component society be placed on the retired list.

Amend Article by adding, "The Council may authorize the remission of dues of any member on recommendation of his County Medical Society for reason. The Secretary in such cases shall recommend remission of dues by the American Medical Association."

Respectfully submitted, WARREN W. FUREY, M. D., *Chairman.* PLINY R. BLODGETT, M. D., FRED H. DECKER, M. D., *Committee on Constitution and By-Laws.*

DR. WARREN FUREY, Chicago: In the report of the Constitution and By-Laws Committee on pages 124 and 125 of the Handbook, you have the recommendations of the Committee. Since coming to the Hotel we have had some conferences with the officers and members and therefore the Committee would like to make the following additional recommendations:

1. Amend Article IV, Section 6 of the Constitution, *Past Service Members,* by deleting the words, "become totally and permanently disabled", and substituting the words, "by reason of age or mental or physical incapacity retired from active practice."

2. Amend Chapter IX, Section 3 of the By-Laws (page 17), "The Committee on Medical Service and Public Relations shall consist of *three* members, by deleting the word "three" and substituting the word "five". It will then read: "The Committee on Medical Service and Public Relations shall consist of five members."

3. The Constitution and By-Laws Committee recommends passage of the resolution presented by Dr. Walter Bornemeier regarding the presentation of a resolution to the House of Delegates of the A. M. A., suggesting relief from dues for Emeritus and Retired or Past Service members.

THE PRESIDENT: That will be referred to the proper Reference Committee.

COMMITTEE ON CRIPPLED CHILDREN'S CLINICS

Crippled Children's Clinics in Illinois are well organized and well publicized. The majority of clinics have hospital connections so that operative treatment can be carried out promptly. The principal ones being:

1. The Illinois Elks Crippled Children's Committee.

2. Division of Services for Crippled Children, University of Illinois, under the supervision of Dr. Herbert R. Kobes.

3. A number of independent Crippled Children's Clinics sponsored by individual County Medical Societies.

The Elks Association:

Clinics Held—1950	150
Total Examinations	3,041
Number cases hospitalized	163
Number hospitals used	15

Division for Crippled Children, University of Illinois, supervised by Dr. Herbert Kobes, included the following:

Site of Clinic	*No. of Clinics*	*Average at each Clinic*
Alton	6	60
Anna	1	45
Aurora*	6	26
Bloomington	4	45
Cairo	4	43
Carrollton	2	48
Casey	2	59
Centralia	2	80
Chester	2	32
Chicago Heights	7	43
Clinton	2	58
Danville	4	56
DuQuoin	2	53
East St. Louis	12	61
Effingham	1	90
Elgin*	4	36
Evergreen Park	5	38
Fairfield	2	80
Flora	1	85
Glenview	3	30
Golconda		
Hinsdale	12	50
Jacksonville	2	44
Joliet*	6	45
Litchfield	3	55
Macomb	3	41
Mt. Vernon	2	75
Metropolis	1	44
Monticello	1	61
Normal*	8	43
Peoria	24	76
Pittsfield	2	32
Quincy	3	61
Rockford	12	47
Rosiclare	1	74
Salem	2	94
Shawneetown	1	65
Shelbyville	2	68
Springfield*	12	42
Sterling	6	49
Tuscola	1	56
Urbana-Champaign	1	21
Watseka	3	26

**Half Day Clinic.*

Crippled Children's Clinics held in Chicago and suburbs in Cook County:

University of Chicago Bobs-Roberts Memorial Hospital.

Clinics held weekly: 6

Approximate number of children's visits—1,406.

University of Illinois

Clinics held weekly: 10

10,440 children treated during 1950. 3,067 of these were children under the age of 14.

Loyola Medical School. Clinics given at Mercy Hospital.

Two spastic clinics per month.

Number of children treated not available.

Northwestern Medical School: Montgomery-Ward Clinic

Clinics held weekly: 4 for children

No breakdown on number of crippled children.

Chicago Medical School: In connection with Mt. Sinai Hospital.

Clinics held weekly: 2

Clinical visits: 250. A small percentage of this number are orthopaedic cases.

St. Luke's Hospital

Clinics held weekly: 3

Approximate number of children per week: 50

Michael Reese Hospital

1 orthopaedic clinic weekly for children. 422 individual cases. 1,206 clinical visits.

1 cerebral palsy clinic weekly for children. 78 individual cases. 242 clinical visits.

Presbyterian Hospital: Central Free Dispensary

Clinics held weekly: 3

Clinical visits: 183

Provident Hospital

Clinics held monthly: 12

Exact number of crippled children treated not available.

Shriners Hospital

Clinics held: 100 per year

Clinical visits, not available.

Children's Memorial Hospital

Clinics held annually: 48

Approximately 500 patients treated.

Cook County Hospital: Fantus Clinic

Clinics held weekly : 6

8,468 patients treated. Of these 1,227 were children.

Cook County Department of Public Health.

Weekly Physical Therapy Treatment Clinics held in the following towns in Cook County:

1. Berwyn
2. Des Plaines
3. Harvey
4. Chicago Heights
5. Maywood
6. Evergreen Park

Number of crippled children treated is not available.

CONCLUSIONS—The majority of Crippled Children's Supervisors give authoritative statistical data willingly. In several, repeated contacts were necessary to obtain information. In a few the reports were meager and unsatisfactory. In a minimal number inquiries met with no cooperation.

CRIPPLED CHILDREN'S CLINICS OF CHICAGO—The majority of these are located in institutions which have medical school connections. Accordingly they are usually staffed by orthopaedic surgeons who also have staff appointments on the teaching schools. It seems that this arrangement makes for a better appraisal of each case.

The types of cases are gradually changing. Fewer tuberculosis cases are seen particularly of the chronic osseous type. Cases of rickets, which were so prevalent in the clinics years ago are again being seen and are appearing in increasing numbers.

Downstate clinics are held throughout the State in most of the counties. In some sparsely settled districts the locations of these clinics necessarily are farther apart. However, the accessibility of these clinics is such that all crippled children can be brought to them regularly. They are held from one to four times a year.

Respectfully submitted, FRANK G. MURPHY, M. D., *Chairman.* RALPH P. PEAIRS, M. D., CHARLES PAPIK, M. D., HERBERT R. KOBES, M. D., GERARD N. KROST, M. D., *Crippled Children's Clinic Committee.*

EDUCATIONAL COMMITTEE

Even though the Educational Committee held only one meeting during the past year, the results of its numerous activities reflect the close-knit cooperation between the individual members of the Committee carried on by correspondence and telephone.

TELEVISION—The gold statuette award, presented to Health Talk by Television Forecast, which stemmed from more than 41,000 votes by its subscribers, was a highlight in the second anniversary year on WGN-TV. This was particularly significant because the award came from the people and not from a group of judges. Presentation of the award was made on the program by Mr. Robert A. Kubicek, president of the firm that publishes Television Forecast, to Dr. Harry M. Hedge, who as President accepted it in behalf of the Illinois State Medical Society.

Many "firsts" have been established by Health Talk which has brought favorable publicity in the press, The Chicago Tribune, Chicago Daily News, The Journal of the American Medical Association, Bulletin of the Chicago Medical Society, News Letter of the American Society of Anesthesiologists, and PR Doctor.

Special interest has been shown in Health Talk, among others, by Medical Economics, the Indiana State Medical Association and the Iowa State Medical Society.

Dr. Theodore Van Dellen has continued in the capacity of moderator for the shows and has contributed very greatly to their success.

The Woman's Auxiliaries to the Chicago Medical and Illinois State Medical Societies took special recognition of the anniversary telecast by sending congratulatory telegrams and presenting a *birthday cake.*

Television Tips, which was prepared by the Educational Committee, also received widespread publicity in the press, in PR Doctor, and in material released by the Metropolitan Welfare Council of Chicago.

Health Talk is on the recommended list for preferred viewing of the Radio Council of the Chicago Board of Education.

The Chicago Dental Society again financed the installation of dental equipment for the telecast, "Your

Child's Bite," and inserted suitable publicity in its bulletin, The Fortnightly Review.

The story of the workshop and a reproduction of the script for "Guardians of Your Sleep" form an integral part of the proceedings of The Twentieth Annual Institute for Education by Radio, which, for the first time, included television as a part of its program.

Credit in no small degree goes to the many firms cooperating in providing equipment for the telecasts.

Recognition also should be given to the five medical schools in Chicago and the hospitals which cooperated in lending equipment to lend authenticity to the telecasts. Special acknowledgment goes to the Medical Department of The Chicago Tribune for providing equipment.

In the mail, many complimentary letters and telephone calls have been received, encouraging the committee as to the type of programs promoted and as to their effective dramatization.

SPEAKERS' BUREAU—This year, 133 Speakers have been scheduled as against 144 for the previous year. Of this total, 17 are for dates beyond the year covered by this report. Six speakers were scheduled on "Medicine As a Career" in the third Career Conference, sponsored by the Sun-Times, The Chicago Technical Societies and the Illinois Institute of Technology. Ten speakers were scheduled in the Youth Week series sponsored jointly by the Chicago Medical Society and the Chicago Board of Education. The files carry numerous communications conveying thanks and evidencing sincere appreciation of the committee's effort in this category.

HEALTH TALK—Health Talk is mailed weekly to 876 and the monthly list is 4,045. In addition, 18 individuals receive a total of 956 issues for distribution among schools and other groups.

Health Talk has won three awards within the last year. In 1950, it took first places in the classification "Publicity Article in Newspaper or Magazine," both in the annual contest of the National Woman's Press Association and again in the annual contest of the National Federation of Press Women. It won another first in the Illinois Woman's Press Association this year, and has been submitted again in the national contest. The committee's Secretary, Miss Fox, deserves full credit and definite thanks for her work that made these awards possible. As always, issues of Health Talk fill a popular need and often quite specific and timely for many communities.

Blue Print, the official publication of Blue Cross featured two issues this past year, "Why a Case History?" and "That Tired Feeling!"

Among many letters received complimenting Health Talk is this one in the mail, from the American Book Company: "We are in the process of preparing an interesting health reader series. Your publication, Health Talk, has been highly recommended to us. We would appreciate your sending us copies of this publication."

Because of the increasing demands being placed on the mailing list, the Committee considered it expedient, except in certain special and very exceptional instances, to restrict Health Talk to Illinois.

RADIO—*"Your Doctor Speaks"*: This transcribed radio series was launched over FM Station WFJL in February, 1950, and continues once each week to meet widespread popularity.

"Here Is Your Doctor": In July, 1950, a second transcribed series was started over Station WCFL. Dr. James P. Shortall, Medical Director of the Chicago Federation of Labor, was given Council clearance to appear weekly in the transcribed series, and this program continues each week with other physicians associated with Dr. Shorthall.

"You and Your Baby": Also in July, 1950, a "live" series began on Station WAAF, with Secretary of the Committee appearing each week. This program was of the nature of questions and answers with physicians answering questions. So popular was this series that it was repeated.

A second series on adolescent problems is now being developed for the same station at the request of the program director, Del Hester.

AWARDS—Special attention should be given to the awards which have been received by the Committee this past year. A total of five first places for special writing divisions (weekly releases, publicity, TV scripts) in the contest of the Illinois Woman's Press Association and the National Federation of Press Women, in one year is significant, as is the gold statuette presented by Television Forecast. Interestingly enough, Health Talk on Television and Health Talk, the publication, won the honors.

PACKAGE LIBRARIES—Fifty-four package libraries were lent to physicians, teachers, and students during the year on the following subjects:

Heart Disease, Skin and Cosmetics, Tetanus, Food and Health, The Feet, Adolescence and Leisure, Multiple Sclerosis, Physical Examinations, Baldness, First Aid, Sex Education, Physical Changes which affect Life, High Blood Pressure, Alcohol and Its Effects, Tobacco, Posture, Allergy, Cancer, Health of the School Child, Venereal Disease, Growing Old Gracefully, Vascular Disease, Progress in Medicine and Surgery, Superstitions or Health, Cerebral Palsy, Health Education, Rural Health, Epilepsy, Migrane Headaches, Geriatrics, The Menopause, Preschool Child, Antibiotics, Preoperative Preparation, and Bacterial Warfare.

MISCELLANEOUS—The Committee reviewed scripts for radio and television for such groups as the Abraham Levinson Foundation, Arthritis and Rheumatism Foundation. The Planned Parenthood Association also requested approval of scripts, but the Committee withheld its approval because of the propaganda nature of the material (none of the work of the Educational Committee deals in any manner whatever with propaganda.) Approval was also withheld from material of the Illinois Society for Metal Hygiene, because actual scripts were not submitted. The Committee wishes to submit to the House of Delegates that it has attempted to uphold its wishes in the clearance of physicians on radio and television, but realizes that

it is impossible to do a complete effort unless allied organizations and individual physicians request the assistance of the Committee.

The Education Committee would appreciate action of the House of Delegates in establishing a policy of ethical clearance for those individuals who may be considered for appearance on television programs, and/or radio programs. The committee has in fact gone on record in its last meeting "to beseech the House of Delegates to" so act at the 1951 Annual Meeting.

With the increase in the activities of the Committee and an unusual amount of illness among the Chicago personnel, there was considerable pressure on individual members of the staff. The death of one part-time employee created a vacancy which was difficult to fill. The Committee considered it expedient to employ a part-time stenographer in the office to relieve the pressure of its personnel and to expedite necessary activity.

Reluctantly the Committee admits that the Secretary was not able to attend as many meetings of allied groups as is considered essential. She has worked cooperatively with many organizations active in various ways with efforts in which "medicine" is interested, with the Chicago Board of Education, the Illinois Congress of Parents and Teachers, Health Education Committee of the Welfare Council of Metropolitan Chicago, the Institute of Friends of the Land, the Illinois Woman's Press Association, Special Color Television Preview of Columbia Broadcasting System, The Illinois Epilepsy League, and Midwestern Writers Conference.

In addition, the Secretary addressed the Woman's Auxiliary to the Chicago Mediacl Society and the following branch auxiliaries: West Side Branch, North Side Branch and the Polish Medical Auxiliary.

As is customary, special letters, programs, agenda and instructions were mimeographed for the Woman's Auxiliary to the Illinois State Medical Society for its annual meeting as well as special letters and agenda for its March 15 meeting.

Radio and television time was also obtained for the Woman's Auxiliary to the Chicago Medical Society in connection with its essay contest and nurse recruitment program.

Other activities included the preparation of the "News of the State" pages in the Illinois Medical Journal, the column for "The Common Good," the obituaries, the publicity in the Bulletin of the Chicago Medical Society, the JAMA, faculty bulletins of the medical schools, publicity articles in TV Forecast and TV Times, as well as other press releases covering various activities.

The Committee continued to carry on the work for the Committee on Medical Economics, Scientific Service Committee and the Postgraduate Education Committee.

With the official sanction of the House of Delegates and the Council of the Illinois State Medical Society, the Committee has made every effort to fulfill and extend its obligations and responsibilities. It is deeply appreciative of the splendid cooperation among the personnel in the Monmouth and Chicago offices, and of the close working relationship with the staff of the Chicago Medical Society.

Respectfully submitted, CHARLES P. BLAIR, M. D., *Chairman.* FORD K. HICK, M. D., *Co-Chairman,* GEORGE L. DRENNAN, M. D., JOSEPH T. O'NEILL, M. D., KARL L. VEHE, M. D., MISS ANN FOX, *Secretary, Educational Committee.*

ETHICAL RELATIONS COMMITTEE

It is most gratifying to the members of your Committee to report to the House of Delegates that this Committee has not had a single assignment referred to it since its appointment. This is again evidence of the good will, unity and good public relations that prevail among the members of the medical profession of this State.

Respectfully submitted, CHARLES H. PHIFER, M. D., *Chairman.* CHARLES ALLISON, M. D., B. V. ADAMS, M. D., *Committee on Ethical Relations.*

FIFTY YEAR CLUB COMMITTEE

Realizing that there were many physicians in Illinois who had been engaged in the practice of medicine for fifty years or more, and wishing to do them special honor for their long services to humanity, the Illinois State Medical Society appointed a committee and authorized the organization of a Fifty Year Club. This club was organized in 1938. Since that time more than 700 members have been inducted into this organization. And at the present time we have approximately 400 members. Any physician who has practiced fifty years or more, and is recommended by the Society in whose jurisdiction he resides, is eligible for membership.

So far as we have been able to ascertain, this was the first organization of its kind in the United States. Since then, a number of states have organized Fifty Year Clubs. During the past year, your chairman has visited the state medical societies in Indiana, Mississippi, California, and Florida, where he has found the Society members deeply interested in their Fifty Year Clubs.

Each member of our Society is presented with a lapel button on which is inscribed, "Illinois State Medical Society, Fifty Year Club." He is also presented with a nicely framed certificate of membership signed by the president, secretary and the chairman of the council of the Illinois State Medical Society.

Many of our county Societies when inducting a member into this organization, not only invite the members of their organizations and their ladies, but those of the surrounding counties and other personal friends of the candidate. The president of each County Society usually presides at these meetings, and invites the councilor of the district, or some other outstanding physician, to present the certificate and lapel button.

The members of the Fifty Year Club deeply appreciate the annual complimentary luncheon given to our club by the Illinois State Medical Society. Last year, when we met in Springfield, approximately 70 members with their ladies attended the luncheon. When we meet in Chicago, the attendance usually exceeds 100. At our luncheon meetings members are permitted to

relate the most interesting, or the most amusing experience encountered in their practice. This makes a very interesting program. Many of the old physicians come from distant states to attend our Fifty Year luncheons and meet their old friends.

Members as of April 1, 1951:

Chicago	150
Downstate	238
Total	388

Respectfully submitted, ANDY HALL, M. D., *Chairman.* CHANNING W. BARRETT, M. D., E. H. OCHSNER, M. D., H. O. MUNSON, M. D., *Fifty Year Club Committee.*

DR. ANDY HALL: Each year I request the Secretary of the State Society to send me a list of the fifty year men. This year he sent me a list of practically 420. On checking them over, I found the names of those who have been dead three or four years. The Secretary has no way of finding out who is dead unless the physicians of the various counties notify him. We have approximately 400 members of the Fifty Year Club and so far I have had requests for more than 85 reservations for our Fifty Year luncheon. I think it is a pretty good percentage when you figure that you get 20 per cent of men attending the luncheon who are past 75 years of age. Please, if any physician dies in your community kindly notify the State Secretary so he can keep his records up to date.

INTERPROFESSIONAL RELATIONS COMMITTEE

The Interprofessional Relations Committee would like to report that the committee has had several meetings as individuals and two meetings in conjunction with the Dental Branch of the Interprofessional Relations Committee and the Interprofessional Relations Committee of the Pharmacists of the State of Illinois. Programs of mutual problems of these three organizations have been considered and talks are in progress for further consideration of consolidation of ideas.

Respectfully submitted, WAYNE B. SLAUGHTER, M. D., *Chairman.* F. M. HAGANS, M. D., FRED H. MULLER, M. D., WADE C. HARKER, M. D., ROBERT B. RUTHERFORD, M. D., *Interprofessional Relations Committee.*

COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health calls to your attention the need for continued resistance against efforts to establish a pattern of socialized medical care for the industrial workers of Illinois. The State Department of Labor has declared its forthright interest in the health and welfare of workers and seeks control over all facilities relating to the health of the industrially employed. Since apparently the objective of socialized medicine cannot be obtained at the federal level through a plan of taxation, efforts are being made to set up a comprehensive program of medical service at the state level through labor-management contracts and legislative enactment. The pattern of employer-labor contracts to provide medical, surgical, maternity and hospital benefits for workers is becoming more inclusive with rigid fee schedules at lower cost. It is reported that organized labor is now considering a plan to take over the health, welfare, pension and insurance plans from commercial insurance carriers and handle these benefits on a non-profit basis.

On December 22, 1950 Governor Stevenson ordered the liquidation of the Division of Industrial Hygiene in the State Department of Public Health and thereby cleared the way for this medical responsibility to be taken over by the State Department of Labor. This arbitrary action by the chief executive was taken without consulting any representative of the State Medical Society or the Director of the State Department of Public Health. The Council of the Illinois State Medical Society resented this repudiation of confidence and at its meeting on January 7, 1951 unanimously adopted a resolution of the opinion that industrial hygiene is a medical problem and the responsibility for industrial hygiene in state government should be delegated exclusively to the Department of Public Health. A legislative bill to this end sponsored by the State Medical Society has been introduced in the 1951 general assembly. Your committee urges every member of the Society to actively support Senate Bill No. 396.

During the past year considerable discussion has been directed toward the development of a rehabilitation service in Illinois. There is urgent need of a program to coordinate existing facilities and establish additional means whereby a greater number of handicapped persons may receive adequate and effective restorative treatment following injury and disease. There is an enormous wasting of our productive capacity by hundreds of persons in need of a directed program to lessen their dependence and give them a self-supporting status. It is the moral and professional responsibility of the medical fraternity to actively participate in this endeavor. The American Medical Association through the Council on Industrial Health has recognized this need in our national economy and has been particularly active in stimulating consideration of a constructive program for rehabilitative service in Illinois.

Your committee wishes to express its appreciation to various members of the Illinois State Medical Society who have participated with us in meetings, discussions, conferences and publication of papers on specialized aspects of industrial health.

Respectively submitted, JOSEPH H. CHIVERS, M.D., *Chairman,* R. J. BENNETT, JR., M.D., D. B. FREEMAN, M.D., H. A. VONACHEN, M.D., R. I. BARICKMAN, M.D., O. B. BOYD, M.D., *Committee on Industrial Health.*

MATERNAL WELFARE COMMITTEE

The Maternal Welfare Committee has been actively engaged in studying the problems in the medical field that relate to the care of mothers and newborn infants. Since the basic factor in the protection of pregnant women is to discover and combat those factors which have led to maternal mortality, the committee has felt that a thorough study of each fatal case is essential for at least three reasons:

1. To acquaint the members of the committee with the cause of maternal death in Illinois.

2. To evaluate the reports of fatal cases which have been carefully assembled by a member of the State Department of Public Health, and to furnish an impersonal critical report to the doctor who handled the case if requested to do so.

3. To summarize for the profession of the state important data on the causes of maternal mortality, to the end that these may be avoided in the future.

The first two of these objectives have been accomplished and the third is being undertaken as of this year. The available data has only recently become of sufficient amount to permit drawing valid conclusions from a statistical point of view.

Papers will be written by various members of the Committee, reviewed by all members and published in the State Journal after review by the Editorial Committee of the Illinois Medical Journal.

The work of assembly of facts about a given case which died has been carefully and thoroughly carried out by Dr. Charles Newberger under the general direction of the committee. It is significant that this has been carried out with little or no resentment or opposition from the members of the society involved in handling the case. This we feel is of major importance to the success of the program.

Another phase of the committee's work has been the discussion of plans for the care of mothers and newborns in the event of atomic warfare in any part of the state, but especially in the Chicago area. According to the experience in London during the air raids the pregnant women were given first priority on hospital beds and their stay in the hospital was curtailed to a few days. This plan may require adjusting to fit special conditions such as the radiation burns which will be serious in some of these patients. Dog tags showing the blood type and the Wassermann and Rh factors should be furnished to each patient to facilitate and expedite transfusion when necessary.

These patients will have to be admitted to the hospitals even if it necessitates turning out other sick patients. Available doctors may have to deliver cases in 12 hour shifts. Special provisions will have to be made for the care of large numbers of premature babies.

The E.M.I.C. program or some modification thereof is under consideration by the Committee and as soon as any plan is formulated and presented the Committee will study it and report immediately to the Society through the President and/or Secretary. It is hoped by this means to avoid some of the difficulties that arose in the operation of the previous E.M.I.C. program.

A Bill is being introduced into the legislature modifying the present registration of stillbirths to include all stillbirths irrespective of the gestation period. This is sponsored by The World Health Organization in the Third World Health Assembly, The American Public Health Association at its annual meeting, The State and Territorial Health Officers' Association, The United States Public Health Service, The Association of Maternal and Child Health and Crippled Children's Directors, and The United States Children's Bureau.

A copy of this Bill has been sent by the Chairman to each member of the Maternal Welfare Committee, and it is being studied and will be discussed at the next meeting of the committee.

The personal reaction of the Chairman is that little of statistical value would be realized from such registration since the cause of death in macerated newborns under five months gestation is in most cases manifestly impossible to determine, and it is for this reason in all probability that they were excluded in the registration of stillbirths when such registration was originally contemplated.

Respectfully submitted, FREDERICK H. FALLS, M.D., *Chairman,* JAMES C. CAREY, M.D., CHARLES E. AHLM, M.D., JAMES E. WALLER, M.D., MILTON E. BITTER, M.D., RALPH R. LOAR, M.D., CARL GREENSTEIN, M.D., W. R. YOUNG, M.D., WILLARD C. SCRIVNER, M.D., A. B. OWEN, M.D., JOSEPH T. O'NEILL, *Committee on Maternal Welfare.*

COMMITTEE ON MEDICAL ECONOMICS

As is customary, the Committee held its one meeting of the year on May 23, 1950, during the Annual Session of the Illinois State Medical Society. Because of the fact that certain members of the Committee were contributing more than their one stipulated article a year and because certain members of the Committee did not contribute any, it was unanimously recommended that the membership be changed.

The criticism of the Committee has always been that the articles submitted were not within the realm of medical economics subjects. With this thought in mind, the Committee agreed to stimulate interest and awareness among its own membership for the need of adhering to the proper theme for which the Committee was created, namely, the publication of one article a month in the Illinois Medical Journal on some phase of medical economics.

In April, 1950, an article titled "School Physical Examination" was published. Because no material was available the Committee was not represented in the Illinois Medical Journal during May, June, July and August. However, the interim brought forth numerous contributions which established a firm backlog, and articles have appeared since then with the exception of October and January when lack of space made omission necessary: "The Basic Economics of Obstetrics"—September, 1950; "Application of Radio-Isotopes as a Career for Physicians"—November, 1950; "Why We Study Medicine"—December, 1950; "The Call of the Wild"—February, 1951; "You and the Blue Shield"—March, 1951 and "Practice of Pathology in a Hospital"—April, 1951.

The response of the members of the Committee has been exemplary for the backlog of material now on file, approved by the Committee members but not published, as such articles as: "The Specialty of Anesthesiology," "The Supply of Public Health Physicians," "The Counterpart of Hoarding," "From Dusk Till Dawn," "Expensive Statistics," "Revised Mental Health Act," and "State Hospital Service as a Career for the Physician." Of the twelve members of the Committee,

three did not submit articles. However, three guest editorials were written, none of which have yet been published. One member of the Committee submitted two articles.

It is interesting that one paper, "Why We Study Medicine," attracted widespread press coverage. The statistical and personality analysis was based on admissions to the University of Illinois College of Medicine. In addition to the press coverage, the author received many requests for reprints. Without doubt, this was one of the most important contributions published in the Illinois Medical Journal for quite some time. Other state medical journals have reprinted the article and to Dr. Carroll Birch, the author, goes credit for making such an interesting and valuable study.

The Committee has earnestly endeavored to meet its obligations and hopes that, while the report does not show consecutively published articles, the backlog of seven unpublished articles is proof of conscientious interest. The Committee also hopes that the subject matter of the individual articles reflects a more accurate interpretation of its function.

Respectfully submitted, CHAUNCEY C. MAHER, M.D., *Chairman,* JOHN R. WOLFF, M.D., *Co-Chairman,* EDWIN F. HIRSCH, M.D., CARROLL BIRCH, M.D., HUBERT L. ALLEN, M.D., FREDERICK SLOBE, M.D., EDWARD W. CANNADY, M.D., FORD K. HICK, M.D., W. ROBERT MALONEY, M.D., ROLAND R. CROSS, M.D., ALFRED P. BAY, M.D., FREDERIC T. JUNG, M.D., *Committee on Medical Economics.*

COMMITTEE ON MEDICAL HISTORY

The work of the Committee has proceeded satisfactorily during the year. Three meetings have been held at which time various subjects have come up for discussion.

The accumulation of the "Data for Biographies of Physicians" is almost complete. There are still a few more to come in. These are now being analyzed. Mrs. Plice of the Auxiliary in Chicago has been most helpful in assisting with this project.

Mrs. Vil, chairman of the Woman's Auxiliary History Committee of Chicago, is doing an effective piece of work in asking her Chairmen and members of each Branch Chapter to participate in collecting data on Hospitals and Nursing Schools in Chicago. If downstate members will assist in the same way the Hospitals with Nursing Schools data will soon be finished.

Short biographies of the Fifty Year Club have been compiled. The list will be amplified.

A compilation of Illinois Medical authors has been made. This is for those who have written books. It would be helpful if all members of the Society would send in a list of such authors with the name of the book or books he has written or what deceased members have written. If any members have written non-medical books we would like to know that also. A post-card sent to Miss Salmonsen with the data will suffice.

The biographical data on all Presidents, Vice Presidents and Secretary-Treasurers of the State Medical Society has been completed with the exception of minor details.

There are approximately ten county histories submitted and others are about ready. Dr. Thomas Kirkwood is completing a fine county medical history of Lawrence County.

On November 28, 1950, a meeting (luncheon) was held at the Sherman Hotel at which were Drs. Hutton, Camp, Davis, Simonds, Moore, Serles (Dean of the University of Illinois School of Pharmacy), Mr. Leary and Miss Salmonsen were also present. Dean Serles presented an outline of a proposed Chapter or section on the History of Pharmacy and the Practice of Medicine. He emphasized the importance of the Apothecary to disease in the early years of the Illinois Country. He gave many interesting items relating to early prescription writing and stated that many physicians were pharmacists at that time.

Dr. Davis presented the attached outline of Sections or Chapters for Vol. II of the proposed History. The titles and names of writers are tentative for the present. Many of the contributors are at work, some have already completed their Chapters. The several items were discussed at length. The meeting adjourned with the understanding that early next spring (1951) another meeting of the Committee will be held at which time further discussion of the chapters and items will continue.

The Committee has had the valuable assistance of the following: Dr. Hedge, President; Dr. Camp, Secretary; and Dr. Blair, Chairman of the Council; and Mr. James C. Leary, Public Relations Counsel.

Respectfully submitted, JAMES H. HUTTON, M.D., *Chairman,* D. J. DAVIS, M.D., *Permanent Historian,* J. P. SIMOND, M.D., *Chairman C.M.S. History Committee,* J. J. MOORE, M.D., GEORGE W. COLEMAN, M.D., CHARLES P. BLAIR, M.D., E. H. WELD, M.D., D. D. MONROE, M.D., ELLA M. SALMONSEN, *Assistant to Historian and Committee.*

HISTORY OF MEDICINE IN ILLINOIS, VOL. II.

TENTATIVE OUTLINE OF CHAPTERS OR SECTIONS
Committee Meeting, November 28, 1950.

1. Introduction—including a general review of Dr. Zeuch's book (Vol. I) by Dr. James H. Hutton.
2. Medical Geography of Illinois (Dr. D. J. Davis).
3. Pre-Civil War Period (?) 1850-1869. Organization Period. (Influence of Virchow, Darwin, Leidy, Holmes, etc.)
4. Civil War Medicine (?)
5. Medical Specialism in Illinois (Introductory) (Dr. D. J. Davis).
6. Medicine and Public Health (1877) Review of the rise and fall of disease in Illinois, etc. (?)
7. Surgery (Dr. Kellogg Speed)
8. General Medicine (Dr. George Coleman)
9. Obstetrics (Dr. F. H. Falls) Midwifery, Home obstetrics, hospital obstetrics, etc.)
10. Pediatrics (Dr. Hoyne and others)
11. Ductless Glands, etc. (Dr. Hutton)

12. Pathology (Drs. J. P. Simonds and J. J. Moore)
13. Bacteriology (Hektoen, Weaver articles augmented and reviewed by Dr. Simonds)
14. Dermatology (Dr. B. B. Beeson)
15. Neurology and Psychiatry (Dr. Hawkinson)
16. Medical Education (Drs. Davis, Strong and others)
17. Apothecary Shops, Pharmacy, etc. in Relation to Medicine (Dean Serles)
18. Ophthalmology (Dr. E. V. L. Brown); possibly also Otolaryngology.
19. Dentistry and Medicine (Dr. E. J. Ryan)
20. Medical Journals in Illinois (Dr. Fishbein)
21. History of State Medical Society (Drs. Camp and Black) see monograph.
22. History of Other Medical Societies in State (Dr. Camp and others)
23. Peoria, Fort Clark, etc. (Medical History by Dr. O. B. Will of Peoria. Printed in Bull. Chicago Soc. Med. Hist. Vol. 1, p. 37, 1911)
24. Adams County History Centenary 1950 (referred to Dr. Hutton)
25. County Medical Society Histories. Completed about 10-12 counties (referred to Miss Salmonsen)
26. Legal Medicine in Illinois.
27. Woman's Auxiliary, History.
28. History of Medical Women in Illinois (Dr. Ruud)
29. Anatomy in Illinois (Dr. O. F. Kampmeier. Also Medical Libraries in Illinois)

Suggested Outlines for Chapters.

1. Each writer should create his own historical outline.
2. Tentative—Historical approach to:
 a. Anatomic and physiologic basis.
 b. Nature of diseases in specialty.
 c. Personnel of workers in the specialty (Biographical)
 d. Historical relations to other specialties and to general medicine.

COMMITTEE ON MENTAL HYGIENE

The Committee on Mental Hygiene, during the year, reviewed a five reel film on mental health and recommended its adoption.

It cooperated with the existing Mental Health groups and societies in this and other states.

It has taken special interest in the work for mentally handicapped children. The chairman was active in the organization of a research program on behalf of mentally deficient children.

The Committee advises closer cooperation between the existing mental health groups.

The committee again deplores the long time it takes for admission of children to the Dixon and Lincoln State Hospitals.

Respectfully submitted, ABRAHAM LEVINSON, M.D., *Chairman,* MANDEL SHERMAN, M.D., GERALD M. CLINE, M.D., WALTER M. WHITAKER, M.D., RUDOLPH G. NOVICK, M.D., *Committee on Mental Hygiene.*

COMMITTEE ON MILITARY AFFAIRS AND EMERGENCY MEDICAL SERVICE

Your committee feels that great progress in the development of the medical phase of civil defense has been recorded during the past year. Further progress will depend on the extent to which individual physicians and county medical societies cooperate over the next few months in completing organizational details.

Annex V, "Health Services" of the State of Illinois Civil Defense Plan was developed by Dr. Henrietta Herbolsheimer in frequent consultation with this committee. (Dr. Herbolsheimer is Coordinator for Health Services in the Illinois Office of Civil Defense, on loan to that Office from the office of Dr. Roland R. Cross, Director of the Illinois Department of Public Health.)

Indicating this close relation existing between the State Director of Civil Defense, Lenox R. Lohr, and the medical profession, the final draft of the Health Services Annex was submitted to the Council of the Illinois State Medical Society for approval January 7, 1951, prior to its final adoption and release January 10, 1951. This plan for the care of medical casualties within Illinois has been sent to the secretaries and civil defense chairmen of all county medical societies. The manual "Health Services and Special Weapons," published by the federal Civil Defense Agency, was included in this mailing.

These documents provide adequate basic principles and technical information in the approved pattern of administrative planning, so that any community within this state should be able to move forward in such a manner as to accomplish an adequate, simple and flexible medical organization.

It is expected that professional non-professional, and non-technical volunteer personnel within the civil defense health services will obtain specific guidance and training through courses in related subjects through state and local civil defense agencies.

To implement the health services plan in each local civil defense jurisdiction, it will be necessary to integrate the efforts and abilities of the organized medical profession within each community with the official local civil defense organization. In anticipation of that need, each county medical society was requested to appoint a chairman for civil defense early in 1949. It is strongly urged that these chairmen make themselves readily available to their local civil defense authorities, and keep themselves freely informed of all phases of civil defense within their communities having any medical aspect.

The Health Services Annex of the State of Illinois Civil Defense Plan states as follows:

"Professional and Technical Societies

"State and local societies of Health Services Personnel are invited to:

"(1) provide technical advice to the State or Local Office of Civil Defense as the case may be;

"(2) assist in the training and recruitment of personnel;

"(3) transmit administrative and technical policy;

"(4) encourage the full participation of their respective members of the Civil Defense effort."

It is also requested that the county chairmen make themselves available as speakers in their local jurisdiction in order that all personnel within the many facets of civil defense may learn of the functions of the medical division and of its interrelation with other divisions.

Likewise, physicians in active practice and their colleagues in other health and related professions, must be fully informed of the potential dangers that we face and must learn every means of meeting them effectively. It is on these persons that the major burden of providing health services and special weapons defense will fall. If they are not prepared beforehand to assume their responsibilities, no amount of planning or money will succeed in the development of an effective civil defense program. The physician is in a position to inject a realistic viewpoint into all local practical planning and the logistics of civil defense. The medical profession has been concerned over the problems of civil defense for several years. It is now time to stop talking and get to work to implement the state medical plan, which is a composite of the best phases of many plans studied and which is considered to be the most comprehensive and workable plan developed to date in the United States.

The grave uncertainties of the international situation have imposed a unique and unprecedentedly heavy responsibility on the American physician. He is now being called by planning groups throughout the nation to assist in making realistic preparations against the atomic, biological, and/or chemical warfare which might be visited on our nation.

Present-day armed conflict will be a great deal different from the last war as regards civil defense. It was largely theoretical then, and perhaps also psychological. We must realize that in all probability, many of our cities will actually be bombed by foreign powers and that saboteur forces will be unleashed to inflict destruction and chaos in varied ways and with numerous agents. As Dr. Perrin H. Long, member of the Council on National Emergency Medical Service of the American Medical Association, wrote recently:

"We, in the medical and allied professions, must forget petty jealousies and annoyances; we must stop jockeying for position; we must submerge the prestige of individuals and groups, and we must stop being rank individualists, so that when we are called on to function in civil defense, we will not fail."

If the duly chosen representatives of organized medicine in each community do not wholeheartedly offer the services of physicians to the local director of civil defense and serve militantly to organize the health services, that local director may look elsewhere for leadership in this phase of civil defense, and possibly acquire other than "regular" or "orthodox" medical personnel in this command position.

Enabling legislation is now being considered by the General Assembly. This is known as House Bill 311, titled "The Illinois Civil Defense Act of 1951." Provision is made for mutual aid, mobile support, interstate and intra-state agreements. The powers of the governor are defined and financial grants are provided for the activation of the civil defense organization. The following provision is included in the bill:

"All personnel of mobile support teams shall, while on duty, . . . be reimbursed by state for all actual and necessary travel and subsistence expense."

The Council of the Illinois State Medical Society has approved postgraduate instruction of the physicians of this state in the medical aspects of civil defense. It is felt that this may well be accomplished through the medium of nine or ten regional meetings about the state on a physician-population basis. This activity awaits further development.

The coordinator for health services in the office of the State Director of Civil Defense is developing certain forms which will assist each county chairman in an orderly inventory of the medical personnel, physical facilities and medical supplies normally available in that area. These forms will soon be mailed to all counties.

The Woman's Auxiliary to the Illinois State Medical Society is cooperating in surveying its membership and in cataloguing their members and their various skills for maximum utilization within the civil defense organization. This work is going forward with the aid of James C. Leary, public relations counsel of the Illinois State Medical Society. This project and the manner of its execution have received widespread notice and it is being adopted, with necessary variations, by other women's groups active in civil defense, both in Illinois and other states.

A civil defense exhibit, which included five color-sound disaster movies, was a part of the annual Clinical Conference of the Chicago Medical Society March 6-9, 1951, in Chicago. This exhibit was visited by 2,775 persons, who in many cases derived their first comprehensive knowledge of the enormity of the problem from it, leaving better oriented and with the belief that it can be solved, if properly appraised and if all concerned cooperate fully. A similar exhibit will be shown during the annual meeting of the Illinois State Medical Society.

The chairman of this committee has a list of those physicians in Illinois who have had the course in "Medical Aspects of Atomic Explosion," given at the Argonne Laboratory, and will supply you with the names of men qualified to address medical groups on this subject.

The committee has maintained close liaison with federal and state civil defense authorities, with the Council on National Emergency Medical Service of the American Medical Association, the American National Red Cross, the Chicago Civil Defense Corps, the Illinois State Nurses' Association, and other related bodies.

Chicago is well along in its civil defense organization. The Chicago Medical Society has taken an active part in the planning and implementation of the emergency medical and public health division of the Chicago Civil Defense Corps. The "three hypothetical bombs" exercise of September 17, 1950, and the critique conducted by representatives of the National Security Resources Board September 25-29, 1950, proved the comprehensiveness, simplicity and flexibility of the Chicago organization and caused nomination of the Chicago Civil

Defense Corps for an award by Freedom Foundation, Inc., for the best civil defense organization in the country.

A survey of the members of the Illinois State Medical Society, outside of Cook County, follows:

Total, 3,569; general practice, 2,482; specialties, 961; retired, 141; surgery, 165; internal medicine, 157; obstetrics and gynecology, 69; radiology, 52; orthopedics, 34; pediatrics, 73; pathology, 23; ophthalmology, 9; ENT, 165; anesthesia, 19; plastic surgery, 0; neurosurgery, 10; psychiatry, 69; dermatology, 28; urology, 39; public health, 35; chest surgery, 2. Men in service are not included.

This breakdown is also available by counties or area, and may be had by writing to the chairman.

The list of civil defense chairmen of the county medical societies is appended to this report. Some counties have no chairmen, as will be noted. Prompt action in the appointment of a chairman by these societies is desired, in order that the civil defense program may move into the implementation stage with a solid front of representative physicians of organized medicine.

In conclusion, your committee takes this opportunity to reiterate its plea that every member of the Illinois State Medical Society immediately establish through his local leaders the part he will be expected to play in his own circumstances and prepare himself to accept the responsibility. That applies with equal force to all county medical societies. The medical phase of civil disaster control is a great public duty imposed on the medical profession and it would be a great disservice to his community and his profession for any physician to neglect it. We do not know what the next few months or years will bring us. As has been well said of the whole civil defense program, "We must hope for the best—but plan for the worst."

Respectfully submitted, EARL H. BLAIR, M.D., *Chairman*, FRANK T. BRENNER, JR., M.D., PLINY R. BLODGETT, M.D., PHILIP LEWIN, M.D., GILBERT EDWARDS, M.D., KENNETH H. SCHNEPP, M.D., LEO P. A. SWEENEY, M.D., ROLAND R. CROSS, M.D., *Committee on Military Affairs and Emergency Medical Service.*

APPENDIX A

List of County Medical Society Civil Defense Chairmen to Date.

Alexander—Charles L. Yarbrough, 2613 Washington, Cairo.
Adams—Ernst Griep, 1101 Maine Street, Quincy.
Bond—Boyd McCracken, Greenville.
Boone—Earl S. Davis, Belvidere.
Brown—(No county medical society).
Bureau—R. E. Davies, 128 North Spaulding, Spring Valley.
Calhoun—(No county medical society).
Carroll—M. H. Seyforth, Lanark.
Cass—R. A. Spencer, Beardstown.
Champaign—J. B. Christie, 104 West Clark Street, Champaign.
Christian—G. W. Arends, 201 South Webster Street, Taylorville.
Clark—Howard Johnson, Casey.
Clay—Original chairman deceased. No replacement to date.
Clinton—E. C. Asbury, New Baden.
Coles-Cumberland—Lee Steward, 112 South 15th St., Mattoon.
Cook—Warren H. Cole, 1853 West Polk St., Chicago.
Crawford—None appointed to date.
DeKalb—Paul W. Carney, 306 East Lincoln Highway, DeKalb.
DeWitt—Wiley R. Marvel, Weldon.
Douglas—Grant Jones, Arthur.
DuPage—Joseph P. Crabtree, 105 South York St., Elmhurst.
Edgar—E. E. Terrell, Paris.
Edwards—Andrew Krajec, West Salem.
Effingham—S. F. Henry, Effingham.
Fayette—Miller Greer, Vandalia.
Ford—P. W. Sunderland, Gibson City.
Franklin—Chairman moved out of state. No replacement to date.
Fulton—R. W. Glenn, Canton.
Gallatin—W. F. Stanelle, Shawneetown.
Greene—A. D. Wilson, Carrollton.
Hancock—H. J. Collins, La Harpe.
Hardin—(No county medical society).
Henderson—None appointed to date.
Henry—T. B. Carney, 108½ Tremont, Kewanee.
Iroquois—R. F. Donovan, Watseka.
Jackson—J. A. Petrazio, Ava.
Jasper—Kent L. Wattleworth, Newton.
Jefferson-Hamilton—Andy Hall, Mt. Vernon.
Jersey—Reported none willing to accept appointment.
Jo Daviess—Herbert Karolus, Warren.
Johnson—William Thomson, Cypress.
Kane—B. F. Howland, St. Charles.
Kankakee—R. E. Bedard, Volkmann Building, Kankakee.
Kendall—(No county medical society).
Knox—E. G. Behrents, 320 North Kellogg, Galesburg.
Lake—John D. Foley, Waukegan.
LaSalle—William Scanlon, LaSalle.
Lawrence—E. A. Fahnestock, Bridgeport.
Lee—J. L. Tavenner, Dixon.
Livingston—Otis Law, Pontiac.
Logan—L. N. Hamm, Lincoln.
Macon—F. Glenn Irwin, 250 North Water St., Decatur.
Macoupin—F. E. Anspaugh, Virden.
Madison—D. M. Roberts, Alton.
Marion—Harry Ryan, 140½ South Poplar, Centralia.
Marshall—(No county medical society).
Mason—J. W. McHarry, Havana.
Massac—No information to date.
McDonough—Erie E. Wisshack, Macomb.
McHenry—B. B. Neuchiller, Woodstock & Lee Gladstone, McHenry.
McLean—B. F. Hoopes, 227 Unity Building, Bloomington.
Menard—Chairman moved out of county. No replacement to date.
Mercer—Harold T. Little, Aledo.
Monroe—E. H. Schaller, Waterloo.

Montgomery—Nelson Floreth, Litchfield.
Morgan—A. M. Paisley, 401 Farmers Bank Building, Jacksonville.
Moultrie—Phillip H. Best, Sullivan.
Ogle—Robert M. Catey, Oregon.
Peoria—Walter Baer, First National Bank Building, Peoria.
Perry—J. W. Stevens, Du Quoin.
Piatt—William M. Scott, Bement.
Pike—W. R. Malony, Pittsfield.
Pope—L. S. Barger, Golconda.
Pulaski—Chairman deceased. No replacement to date.
Putnam—(No county medical society).
Randolph—R. E. Schettler, Red Bud.
Richland—Lawrence Weber, Olney.
Rock Island—R. O. Sala, 419 19th St., Rock Island.
Saint Clair—John Collins, Murphy Building, East St. Louis.
Saline—Thomas R. Skaggs, Harrisburg.
Sangamon—Nelson Chestnut, 723 South 5th St., Springfield.
Schuyler—C. M. Fleming, Rushville.
Shelby—Louis Chabner, Shelbyville.
Stark—(No county medical society).
Stephenson—V. V. Rockey, 324 West Galena, Freeport.
Tazewell—L. F. Teter, 34 South 4th St., Pekin.
Union—W. A. Schroeder, 205 North Main St., Anna.
Vermilion—E. M. Dewhirst, 106 North Vermilion St., Danville.
Wabash—C. L. Johns, 112 West 5th St., Mt. Carmel.
Warren—W. F. Roller, Monmouth.
Washington—Roscoe C. Vernor, Nashville.
Wayne—L. W. Young, Fairfield.
White—J. G. Harrell, North Walnut St., Carmi.
Whiteside—I. Vandermyde, Morrison.
Will-Grundy—P. C. McGinnis, 86 West Jefferson St., Joliet.
Williamson—M. M. May, Marion.
Winnebago—John L. Probasco, Talcott Building, Rockford.
Woodford—H. T. Barrett, Minonk.

COMMITTEE ON NUTRITION

The Committee on Nutrition held a meeting last July in an effort to create goodwill and assist in publicizing the first Chicago meeting of The Friends of The Land, which was held for the purpose of stressing the relationship of the soil to health and to develop better public relations with the Chicago Federation of Labor and other organizations interested in nutritional health matters.

At this meeting the Committee on Nutrition agreed to ask the President of the Illinois State Medical Society and the Chairman of the Council for some top spots on the program for the 1951 annual meeting. We were promised that this would be given consideration.

Dr. Lee T. Hoyt, member of the Committee on Nutrition, wrote a letter to the Deans of the following Medical Schools: University of Illinois, Northwestern, Loyola and Chicago, also to Dean Rusk of the College of Agriculture, University of Illinois, asking the following questions:

1. What is being offered in the curriculum of our Medical Schools on the relationship between nutrition and health, i. e., courses, textbooks, material and collateral reading?

2. What research is being done in this field and if this research is being correlated with our agricultural colleges or the United States Department of Agriculture?

3. If our committee could in any way be of service in the promotion, improvement or expansion of the teaching or research in this field of medicine.

The replies from the Medical Schools, with the exception of one, were very disappointing and gives us proof of the fact that the teaching of nutrition has not been given proper consideration. The Department of Agriculture, University of Illinois, is working along lines of research which may develop into something worthwhile but they still have a long way to go. They will all have to learn the relation between soil, food and health.

The chairman has had several meetings with individuals relative to establishing a laboratory for electrospectrographic examinations to determine the chemical content of blood and tissue. This should be part of the research laboratory equipment in our universities, especially the Medical Department of the University of Illinois.

Respectfully submitted, G. C. OTRICH, *Chairman*, HARLAN ENGLISH, M. D., EVERETT P. COLEMAN, M. D., JOHN P. O'NEIL, M. D., LEE T. HOYT, M. D., *Committee on Nutrition.*

COMMITTEE ON NURSING

This committee was appointed at the annual meeting last year when it was decided to have a state committee on nursing as per the request of the A. M. A.

The report of the Committee this year is essentially one of progress. The meetings being entirely in the Chicago area were in cooperation with the corresponding committee of the Chicago Medical Society. This committee has been represented at the local meetings of the Chicago Council on Community Nursing, the Layman's Conference on Nursing, the Illinois Hospital Council, etc. The one meeting planned for the committee as a whole, on March 4th, had to be cancelled due to circumstances beyond our control.

Two projects need reporting and emphasizing: 1st. The recruitment nurses program of the Womans Auxiliary of the Chicago Medical Society, which program could be made statewide in its scope.

During 1950 there were 3,000 first year student nurses while there were places for 3,500, leaving a deficit of 500 at the state level.

The Womans Auxiliary of the Chicago Medical Society desires to make the recruitment of student nurses a major project for 1951. They plan a Student Nurses Week which will be from May 6-13. Their plans call for a Poster Contest with a $100.00 prize for the best poster. They also plan on having an essay contest on the subject, "Why I Want to Become a Student Nurse."

2nd. The Illinois Nursing Bill as sponsored by the Illinois State Nurses Association:

This bill provides for a compulsory lincensure of professional nurses and permissive licensure of practical nurses. The professional nursing portion of this bill has one major change from the existing Nursing Act in that it lowers the age from 21 to 20 years of age.

The final draft of the Practical Nursing Legislation was made by a joint committee of the A. M. A., the Illinois State Nurses Association and the Illinois State Medical Society. We were represented at this meeting by Mr. John Neal.

The Chairman wishes to emphasize that this report is merely an outline of its activities and attempted accomplishments. Many of the projects needing its guidance are merely starting and much work lies ahead in the immediate future.

Respectfully submitted, RALEIGH C. OLDFIELD, M. D., HARRY M. HEDGE, M. D., A. J. LINOWIEKI, M. D., EVERETT P. COLEMAN, M. D., I. H. NEECE, M. D., *Committee on Nursing.*

COMMITTEE ON PHYSICAL THERAPY

The Committee on Physical Therapy has contributed abstracts of the significant writings on physical medicine for publication in the Illinois Medical Journal during the past year. The current literature has been reviewed and the important material has been selected to keep the membership of the Illinois State Medical Society informed.

Respectfully submitted, EMIL D. W. HAUSER, M. D., *Chairman,* H. WORLEY KENDALL, M. D., HUGH COOPER, M. D., RALPH P. PEAIRS, M. D., DISRAELI W. KOBAK, M. D., *Committee on Physical Therapy.*

COMMITTEE ON POSTGRADUATE EDUCATION

Since the last Annual meeting the Postgraduate Education Committee has suffered its greatest loss subsequent to its inception. The resignation of Dr. Robert S. Berghoff, who had been the Chairman of the Committee from its organization was a great blow to the Society, the Committee and the program he instituted. Those of us who try to carry on profit by his inspiration and his helpfulness. His services were recognized at a joint meeting September 21, 1950, of the Postgraduate Education and the Scientific Service Committees, which he also headed for many years. Thanks to the organization he set up, the Postgraduate Conferences have continued on a high professional and educational level.

The County Societies as hosts to the conferences scheduled, the speakers who gave of their knowledge and time to present factual information to those in attendance, the staff in the Chicago office, particularly Miss Ann Fox who lined up the programs, all deserve the thanks of the Society and this Committee for their helpfulness. Dr. Camp and the staff in the Monmouth office relieved the Committee of details of the meetings themselves.

Nine postgraduate conferences of the twelve authorized by the Council have been scheduled at the writing of this report. For the first time, a combined conference was held for the Ninth and Tenth Councilor Districts, April 5, in Carbondale. No conference was scheduled for the Sixth Councilor District, while two were scheduled for the Fifth District, one in Bloomington, and one in Pekin, the one extra conference was not requested by another district. The 68 physicians participating in the various postgraduate sessions included:

District Date Place Speaker and Subjects

1 November 29, 1950 Freeport
Irving E. Steck, Arthritis and Allied Conditions; Howard L. Alt, Present Day Treatment of the Common Blood Diseases; Robert M. Grier, The Importance of Clinical Observations of the Last Month of Pregnancy; Hugh A. Flack, Cardiovascular Diseases; Arthur H. Rosenblum, Gastro-Intestinal Allergies in Infants; Harold M. Camp, Voluntary Prepaid Medical Insurance; and Anthony V. Partipilo, Duodenal Obstruction.

2 April 19, 1951 LaSalle
B. M. Kagan, Antibiotics in Pediatrics; Eugene A. Hamilton, Care of Fractures by the General Practitioner; Ralph E. Dolkart, ACTH and Cortisone in a Community Hospital; George Vlasis, Office Gynecology; Joseph B. Kirsner, Current Status of Anti-Secretory Drugs; Harold M. Camp, Voluntary Prepaid Medical Insurance; and Ormand C. Julian, Anticoagulant Therapy.

4 April 25, 1951 Moline
F. Garm Norbury, Office Psychiatry; Arthur H. Rosenblum, Allergy in Infants; George Cummins, Cardiovascular Aspects of Aging; Harry A. Oberhelman, Surgical Treatment of Peptic Ulcer; George Baumrucker, Treatment of the Neurogenic Bladder as Applied to General Practice; Charles D. Krause, Treatment of Obstetrical Emergencies; Richard J. Bennett, The Significant Findings in 2,500 Physical Examinations in Men 65 Years of Age; Percy E. Hopkins, Voluntary Prepaid Medical Insurance; Louis R. Limarzi and Howard L. Alt, Symposium on Hematology.

5 October 19, 1950 Bloomington
Ralph A. Reis, Toxemias of Pregnancy; Chester Coggeshall, Diabetes; I. Pat Bronstein, Pediatric Endocrinology; Mr. John W. Neal, Voluntary Prepaid Medical Insurance; and Danely P. Slaughter, Recent Advances in Cancer Therapy.

5 November 9, 1950 Pekin
Edwin F. Hirsch, Clinical Pathological Conference (James Weimer); Raphael Isaacs, Recent Advances in Diagnosis and Treatment of Leukemia and Anemia; William F. Lauten, Burns; Edwin N. Irons, The Use and Abuse of ACTH in a Small Hospital; James H. Hutton, Office Procedure in Diagnosis and Treatment of Endocrinopathies; Harold M. Camp, Voluntary Prepaid Medical Insurance; and Warren H. Cole, Intestinal Obstruction.

7 November 30, 1950 Effingham
Harry A. Oberhelman, Relationship of Chronic Cystic Mastitis to Cancer of the Breast; Willard O. Thompson, Clinical Uses of ACTH and Corti-

sone; Philip Lewin, Backaches and the Disc Syndromes; Henry Buxbaum, The Management of Occiput Posterior; Fremont A. Chandler, The Management of Fractures of Both Bones of Forearm; Walter M. Whitaker, The Present Day Treatment of Rheumatic Fever; Harry M. Hedge, Office Dermatology; Jacob E. Reisch, Voluntary Prepaid Medical Insurance; and Morris Parker, The Differential Diagnosis of Medical and Surgical Jaundice.

8 April 12, 1951 Champaign
Edwin J. DeCosta, Prolonged Labor; Sidney Rosi, Gastric Surgical Resection versus Gastroenterostomy and Vagotomy; Leonard F. Jourdonais, The Treatment of Medical Emergencies in Diabetes Mellitus; George A. Hellmuth, Newer Advances in Coronary Occlusion; Gilbert H. Marquardt, Geriatrics; Julius B. Richmond, Abdominal Pain in Infancy and Childhood; C. Paul White, Voluntary Prepaid Medical Insurance; and J. Garrott Allen, Medical Aspects of Atomic Disaster.

9 and 10 April 5, 1951 Carbondale
Edwin J. DeCosta, Prolonged Labor; Sidney Smith, Surgery of Congenital Defects in Children; Sol Mackler, Spontaneous Rupture of the Esophagus; Fay M. Whitsell, Vascular Diseases in Relation to the Eye; L. Martin Hardy, Psychosomatic Problems in Pediatrics; Charles Lawrence, Viral Hepatitis; Amos J. Brown, Clinical Aspects of ACTH and Cortisone Therapy; B. E. Montgomery, Voluntary Prepaid Medical Insurance; and LeRoy H. Sloan, Changing Patterns in Medicine.

11 November 15, 1950 Elmhurst
Harry A. Oberhelman, Indications for Surgery in Peptic Ulcer; Clayton J. Lundy, Anticoagulants in Heart Disease; Norris J. Heckel, Chronic Pyelitis; Rollin T. Woodyatt, Diabetes in Childhood; Mr. John W. Neal, Voluntary Prepaid Medical Insurance; and Smith Freeman, Metabolism and Clinical Effects of ACTH and Cortisone.

The work of programing is carried out in the office of the Postgraduate Education Committee as well as the issuance of 556 press releases covering all conferences. The task of sending postal card notices to membership in the respective Districts, the sale of the dinner tickets and other miscellaneous activities are performed by the Monmouth staff.

Because of the economic factor, it was not considered expedient to revise a new List of Speakers. However, some 450 new names were added to the files in response to published requests in the Bulletin of the Chicago Medical Society and the Illinois Medical Journal, and to special letters to the deans of the five medical schools in the Chicago area. It is interesting to note that the many requests for some 950 speakers are not confined to the existing card file, and yet, no physician or allied professional person not included in the regular List of Speakers, has refused an invitation to appear in one of the postgraduate conferences if the date was convenient.

At the joint meeting of the Postgraduate Education and Scientific Service Committees a recommendation was approved that no conference for any District be scheduled closer than two weeks apart within a 100 mile radius.

With the increasing number of postgraduate conferences conducted by other groups, an attempt has been made to have each group clear the dates through the Postgraduate Education Committee to obviate overlapping and duplication of effort. Nevertheless conflicts still occur. Even with the cordial cooperation of County Societies, the American Academy of General Practice and various specialty groups, overlapping continues. Particularly does this hold true in October and April wherein your Chairman finds himself obligated as a Councilor, as well as called upon for various other trips. As he indicated in his last year's Councilor report this sort of a position is a chauffeur's job. Further clearing is recommended.

The attendance at some of the Postgraduate Conferences has been disappointing for reasons given in the preceding paragraph as well as others. Attention has been invited to this in reports to the Council. After all, since the members of the Society pay for these conferences it is incumbent on them as well as the Council and the Committee to see that they get their money's worth.

Along these lines considerable thought has been given to other phases of Postgraduate educational procedures. An evaluation and an analysis of the present program and perhaps an addition or else a shift to the telephone seminars so well carried out by our confreres in the Illinois State Dental Society, by the Indiana State Medical Association and other groups, is being seriously considered in future. A per capita or per diem seminar cost accounting basis is being worked on. If enough interest is expressed this might be a supplemental procedure that will be well worth while. However, even if this is undertaken the type of Postgraduate Conferences instituted under Dr. Berghoff's Chairmanship must still be considered pioneering in this field in the Middle West. The fact that other groups have copied it is in itself the greatest compliment that can be paid to the Illinois State Medical Society, even though attendance at our own conferences suffers thereby.

Another type of postgraduate education that merits serious attention at this time is that of the medical aspects of Civil Defense. Dr. Roland Cross, Director of the State Department of Public Health and your Chairman have referred this to the Council on two occasions. This subject is "hot" by reason of the international situation. The Chicago Medical Society and one County Society that we know of have had special meetings on this topic. While it is to be hoped that the occasion will not arise to utilize information so acquired, our profession cannot and will not assume the ostrich point of view in this important field. Your committee intends to propose active, aggressive, and continuing cooperation with the State Office of Civil Defense in furthering extension of information on this subject.

Respectfully submitted, F. GARM NORBURY, M. D., *Chairman,* GEORGE A. HELLMUTH, M. D., FRANK DENEEN, M. D., CHARLES O. LANE, M. D., R. C. OLDFIELD, M. D., N. C. BARWASSER, M. D., W. W. FULLERTON, M. D., GEORGE KIRBY, M. D., *Postgraduate Education Committee.*

COMMITTEE ON RURAL MEDICAL SERVICE

The past year has been characterized by two important events. The encouragement of Health Improvement Association in 32 counties of the State. The Blue Cross movement initiated these groups, with the help of County Medical Societies, Farm Bureaus, and other interested citizens. The Health Improvement Associations are non-profit *county* groups that provide Blue Cross and Blue Shield coverage to essentially rural people in their home county. From this foundation, a Health Improvement Association can undertake any health project that the board wishes to undertake in that county. These County Health Improvement Associations can easily be the nucleus about which a community health council can develop.

The second thing that the delegates need to know about is the activity of the Farmer-Doctor Loan Fund. The Fund has been active again this year and now has a total of 27 young men in medical schools or internships, who are under contract to return to 22 counties in the worst need of replacement medical personnel. The requirements of the Armed Services are such that these young men will have to serve their military time before being available as physicians back in their home communities. The program is felt to be essentially sound, and if kept up, will go a long way toward "educating for need" in rural Illinois. The doctors and farmers of Illinois have much money invested in these young men, but we feel that it is a good investment since they will serve rural people in need of physicians. The students are at present obtaining medical training in the following medical schools: Northwestern University, University of Illinois, Marquette University, Loyola University, and Washington University.

The number of hospital beds in rural Illinois did not appreciably increase during the past 12 months. Some of the hospitals under construction at the time of the last meeting of the House of Delegates are now opened. These facilities were and are located in areas of need. It would appear that there are about enough beds available for acute illnesses in Illinois, but the problem of the care of the chronically sick and the aged will continue to be with us as our entire population increases its longevity. The proposal that families pay for the care of their relatives in state institutions may alleviate somewhat the burden on our local community hospitals, as well as the state institutions.

Anything the members of the profession can do to increase the enrollment of nurses in nurses' training in any of the hospitals of Illinois, which provide nursing education, should be done. Any assistance that any physician can give to a youngster interested in any of the auxiliary services of medicine, such as x-ray technicians, laboratory technicians, and so forth, should be done, because from our own areas, we must supply the needs of the future.

Respectfully submitted, HARLAN ENGLISH, M. D., *Chairman,* G. C. OTRICH, M. D., W. I. LEWIS, M. D., EDGAR C. COOK, M. D., J. C. REDINGTON, M. D., *Committee on Rural Health.*

Supplement report on ANNUAL CONFERENCE ON RURAL MEDICAL SERVICE at Memphis, Tennessee, presented by Dr. W. I. Lewis:

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The annual conference was held February 23 and 24, 1951, but on the day preceding, February 22, there was a meeting of the National and State Committees on Rural Health of the American Medical Association, this I attended. The general theme of that day's meeting was, "Sparkplugging Rural Health." Registration began at 9:00 a. m., greetings of the American Medical Association given by Dr. J. L. Blasingame of Wharton, Texas, who is a member of the Board of Trustees of the American Medical Association. He spoke of the problem of rural medical service during the past few years and the efforts of the American Medical Association to better such service. He assured the Rural Health Committee that it was the aim and objective of the A. M. A. to continue its fullhearted support in the rural health service movement.

Dr. F. S. Crockett of LaFayette, Indiana, Chairman of the American Medical Association Rural Health Committee next spoke on "sparkplugging" rural health. He spoke of the need for full cooperation of all physicians and lay people; he also mentioned that physicians should do their part as citizens and not just as doctors alone. He deplored the fact that many doctors are laggard in this respect, that they pay little attention to community and health problems. He commended the States of Iowa and Illinois on their health associations, also mentioned the Student Loan Fund of the State of Illinois which, he thought, was a great aid in supplying physicians to certain needy rural communities.

Following Dr. Crockett, Mr. Aubrey D. Gates Field Director, Committee on Rural Health of the American Medical Association, spoke on the responsibilities of rural health. He stressed the collective cooperation of the medical profession and the lay people on all problems relating to rural health improvement. As an example, he cited the malaria control in the South, also the stamping out of pelagra in the South. He continued his discussion by mentioning the nutrition responsibility, sanitation control, water and milk supply, the latter particularly for its connection to brucellosis and tuberculosis. He brought out the fact that this is more of a problem in the rural sections while in the urban sections it is regulated by sanitation laws. He discussed the hospital situation, brought out the fact that it is estimated by surveys that at least 2.2 hospital beds are needed per thousand people. He commended the Hill-Burton Act for supplying hospitals or doctors workshops. He stressed, too, the need for broad understanding of voluntary medical care as exemplified in the pre-payment insurance plans. He mentioned that so many people, particularly rural people, will carry all other types of insurance but neglect the voluntary

health insurance; this particularly is so needed in catastrophic illnesses. In his conclusion he stressed the need for full cooperation of the people, physicians, veterinarians, food suppliers, milk producers, farmers grange, in fact, all similar organizations should be included. This talk of Mr. Gates I thought was the most complete and comprehensive of all the program, even including the next two days. Following the talk there was a discussion period until noon and the meeting recessed for luncheon.

In the afternoon at 2:30, Dr. E. K. Yantes of Wilmington, Ohio, talked on "The Medical Aspects of the Clinton County, Ohio, Survey." For your information and for your files I secured a copy of this survey and am enclosing it to you. There was a discussion period following Dr. Yantes' talk.

The next subject, "Problems of Providing, Hospitals in Rural Areas," was discussed. This, of course, as you will note from the enclosed program for that day's meeting had three men on the panel. They mentioned, of course, the Hill-Burton Act an aid in obtaining hospitals from that source. There seemed to be a trend in the need for more unified community action in securing hospitals. In the discussion period following these three speakers several more men spoke on the need for more recognition of the smaller hospitals, for example, twenty or thirty bed hospitals.

The day's meeting was adjourned for a social hour and dinner at 7:00 p. m. In my opinion this first day's meeting was very good.

The National Conference convened the following day, February 23rd. You will note that some of the same speakers participated, the fact of the matter is, Drs. Crockett, Yantes, and Mr. Gates spoke on the general titles of the previous day's discussions. Doctor Lull gave the address of welcome for that day's meeting. I did not keep any notes particularly of this day's meeting because there seemed to be considerable repetition but won't miss telling you of the evening's meeting which began at 8 p. m. Dr. Haven Emerson, member of the Board of Health, City of New York, Professor Emeritus of Public Health Practice, Columbia University, New York, talked on public health and medical care for the community and individual. This was the outstanding talk of the National Conference. Doctor Emerson talked for well over an hour and held his large audience in the ballroom spellbound. He is a most interesting speaker and with his years of experience certainly gave a very informative and interesting address. He mixed enough humor in his talk to keep the audience well entertained.

Following his talk The Peabody Jubilee Singers entertained us for about fifteen minutes. This was a group of about thirty colored boys with two or three girls added for spice. They were all employees of the Peabody Hotel. They sang southern songs, particularly Negro spirituals. It was most entertaining and they received quite an ovation as they marched out of the ballroom. The concluding talk that evening was given by Mrs. Charles W. Sewell, Administrative Director, Associated Women, American Farm Bureau Federation, Chicago, Illinois. She gave a very interesting talk on the American way of life. Suffice it to say, she did not commend the New Deal way of life.

The next day, February 24, was not near as interesting. The part from 9 a. m. to 11 a. m. I must confess, I missed, explanation right here is in order. I must state that for one week prior to this meeting I had had the flu and went to Memphis feeling like "the last rose of summer." The fact of the matter is I remained in my bed over half the time while in Memphis. I probably should not have gone but felt that perhaps two hundred twenty-five miles further South might be beneficial, consequently I attended the meeting. I might add that I continued somewhat under the weather for about one week following my return home but continued with my work. To continue with Saturday's meeting, the 10:30 a. m. discussion period was dispensed with and the time given over to Dr. George F. Bond. He showed a movie with his talk, he being the principal actor in the movie. It was filmed in his territory and followed him as he administered to the rural mountaineers of his section. After the movie he talked for several minutes, this made quite an impression on all present.

I left Memphis shortly after this and did not attend the luncheon or afternoon portion of the program on Saturday.

Respectfully submitted, WILLIS I. LEWIS, M. D.

SCIENTIFIC SERVICE COMMITTEE

During the past year, the Scientific Service Committee met every request for services, whether it was for a speaker, press releases, double or single postal cards. Many of the societies requesting our assistance scheduled their own speakers. The following table indicates the extent of the services rendered:

Societies	*Speakers*	*Double Postal Card Notices*	*Single Postal Card Notices*	*Press Releases*
Bureau	5	985		151
Champaign	1			
DeKalb	5			
DeWitt				36
DuPage	3			
Effingham	9	636		177
Fulton	4			
Henry	4	706	120	70
Iroquois	10	667	85	216
Kane	1			
Kankakee	6			
LaSalle	9	1403		259
Livingston	1			
Logan	2			
McDonough	11	948		269
Macon	1			
Macoupin-Montgomery	5			

Morgan	1			
Sangamon	1			
Six County: (Randolph, Perry, Jackson, Union, Williamson and Franklin)		409	164	78
Whiteside-Lee	12	1129		246
Will-Grundy	8	495		58

Special letters were mimeographed for the Six-County Medical Society and the Henry County Medical Society, 164 and 120, respectively.

Among the 110 speakers scheduled between April, 1950 and March 31, 1951 were the following: Harry A. Gussin, John C. Scully, Lindon Seed, John B. O'Donoghue, Harry M. Hedge, Thomas D. Masters, Theodore R. Van Dellen, Donald S. Miller, H. Close Hesseltine, Joseph N. Rappaport, James R. Webster, George V. Byfield, Eugene F. Traut, Raymond W. McNealy, Harold C. Voris, Paul A. Campbell, James H. Hutton, Edwin Irons, August Daro, Wesley A. Gustafson, Claude N. Lambert, John J. Fahey, J. Charles McMillan, Carlo Scuderi, William W. Bauer, E. Lee Dorsett, St. Louis; Philip Thorek, Martin H. Seifert, Edward A. Piszczek, Hermann Wellmerling, Edward L. Compere, Irving E. Steck, Leo P. A. Sweeney, Louis R. Limarzi, Vernor C. Turner, Ormand C. Julian, George Holmes, John W. Huffman, Paul C. Bucy, Elizabeth Painter, Ph. D., Fred O. Priest, Edwin R. Levine, E. Harold Ennis, John L. Keeley, Ralph H. Kunstadter, Willard O. Thompson, Arkell M. Vaughn, Richard B. Capps, Paul F. Fox, L. Martin Hardy, Frederick Steigmann, Hans von Leden, Morris T. Friedell, Eugene T. McEnery, Theodore R. Hudson, Mr. John W. Neal, Leonard M. Schuman, Morley D. McNeal, Gerald M. Cline, Charles N. Pease, Wayne W. Flora, John J. Brosnan, Herbert E. Schmitz, Francis D. Wolfe, Irwin R. Callen, Jesse A. Stocker, Chester C. Guy, Herbert E. Landes, Frank B. Kelly, James A. Campbell, Lawrence Breslow, Walter Reich, Adrien Ver Brugghen, Charles D. Krause, R. Gordon Brown, Charles F. Alderson, East St. Louis; Richard Allyn, Hans L. Popper, David I. Abramson, Robert J. Hawkins, William B. Raycraft, John P. Coughlin, J. Garrott Allen, Edward D. Allen, George Cummins, Oscar Hawkinson, Jerome T. Paul, Wayne B. Slaughter, Emery G. Grimm, N. C. Gilbert, Herman A. Levy, Charles J. Smith, Elizabeth A. McGrew, and Arthur J. Atkinson.

Of the total, 18 speakers are for meetings beyond this period.

Special groups given service, 11 speakers in all, included the Aurora Medical Society, the St. Anthony May Clinic Day, the Will-Grundy County Chapter of the Illinois Chapter of the American Academy of General Practice, the Ryburn Hospital, Ottawa, the Springfield Medical Club and the Stock Yards Branch of the Chicago Medical Society.

In accordance with instructions from the Council, each speaker was asked whether he wished publicity in his neighborhood paper. It is interesting to note that six physicians did not wish this type of notice.

While the total number of speakers scheduled is a decrease from the previous total of 130, this may in part be accounted for by the fact that the Will-Grundy County Medical Society formerly requested two meetings a month whereas in the last year, thus far, the society has scheduled only 8 speakers.

A public meeting on Poliomyelitis was arranged for the Whiteside-Lee County Medical Societies with two speakers scheduled. From all reports, this was an unusually interesting and well attended session and suggests that the idea can be well adopted by other county societies.

Only 22 county medical societies, exclusive of the special group of six, as compared with 26 county medical societies in the previous report, requested services. This year, the counties of Knox, McHenry, Rock Island, St. Clair, Stephenson and Warren did not ask for any type of service.

The pressure of work in the Chicago Office in carrying out all activities for which it is responsible, may, to some extent, account for the apparent decrease in service. In the last year, for example, it was not possible to contact every county medical society with a personal letter and a blank to indicate the desired services. No attempt was made to reach the county medical societies unless the request stemmed from the individual society. In every instance where assistance was required, regardless of the type of service, the request was filled.

During the year, a Supplementary List of Speakers, consisting of some 450 new names, was compiled. Because of economic and clerical reasons, the List was prepared in alphabetical arrangement and not according to subject. This Supplementary List was mailed to every county medical society with a special letter in October, 1950.

This year, too, at the request of the Council, every county medical society serviced was asked to assume travel expenses for their speakers wherever possible.

While the Committee has met every request from the county medical societies, it again wishes to emphasize the need for setting up meetings well in advance of the date of session. The Committee recognizes that it is not always possible to do this. The procedure, however, not only offers a better opportunity to obtain the specified speaker but permits more time to build up suitable publicity.

At a joint meeting of the Scientific Service and Postgraduate Education Committees, September 21, 1950, a motion was adopted commending Dr. Robert S. Berghoff for his years of leadership in charting the activities of both Committees. The Scientific Service Committee has constantly endeavored to follow his able direction and wishes to acknowledge to the House of Delegates that it has felt the loss of his guiding counsel.

Respectfully submitted, LOUIS R. LIMARZI, M. D., *Chairman*, ROBERT J. PATTON, M. D., WADE C. HARKER, M. D., CHARLES H. HULICK, M. D., J. J. LINK, M. D., HARRY A. OBERHELMAN, M. D., CHARLES D. KRAUSE, M. D., *Scientific Service Committee.*

COMMITTEE ON TUBERCULOSIS CONTROL

Tuberculosis control in Illinois has made distinct advances during the past year in the State and all organizations engaged in the program for eradication of the disease are focusing on new objectives, programs and procedures to continue the favorable trends now initiated. As long as the death rate in Chicago and downstate continues as at present we cannot be satisfied with the status of tuberculosis control but must continue with renewed vigor to reach the ultimate goal—the eradication of the disease in our midst.

Tuberculosis is still a serious disease. There were 7,673 cases reported in 1950, a 3% decline from the record in 1949. The reported cases in 1950 were only 3% below the 9 year median of 8,079. The program for control and eradication is simple but needs severe application of the principles now so well known. We know the cause and the cure, but the formula for carrying out the eradication program involves a definite plan.

(1) Find every infectious case in the community.

(2) Remove all open cases from the community by isolation in suitable sanitaria.

(3) Protect the recovered patient from breakdown after healing by means of accepted methods of rehabilitation.

These basic principles must be adapted to a practical basis from time to time to continue successfully.

The survey programs have gained momentum as time goes on and there is increased interest shown by physicians in diagnosing contact and suspect case. The Illinois Department of Public Health has taken the one-millionth chest roentgenogram in its five year old tuberculosis case-finding program. The first mobile x-ray unit began operation in January 10, 1946. Today five mobile x-ray busses and one transportable unit are in operation. The state health department works closely with local groups who sponsor the surveys, i. e., county tuberculosis associations and sanatorium boards. After the roentgenograms have been processed by the Illinois Department of Public Health, they are kept as a permanent record. Hospital admission x-rays are reaching a great group of apparently healthy individuals that would not be surveyed by other methods, and with increased emphasis on the tuberculosis morbidity in the older age groups this method will find many hitherto uncovered cases in our population.

The Chicago Municipal Tuberculosis Sanitarium purchased the first mobile x-ray machine in the middlewest back in 1936. This was 14 x 17 equipment and found too expensive to operate on a survey basis. It was exchanged in 1942 for 4 x 5 machine. The program in Chicago and Cook County has shown tremendous growth made possible mainly by a joint case-finding agreement between the Municipal Tuberculosis Sanitarium and the Tuberculosis Institute of Chicago and Cook County. From September, 1946 to the end of February, 1951 over 1,424,000 x-rays were taken by the combined equipment of the two organizations. The Statewide Committee for the Eradication of Tuberculosis reaffirms approval of the 1953 chest survey for Chicago and Cook County.

With the notable increase in beds available in Illinois, isolation of open cases becomes increasingly more successful. A six million dollar bond issue has been approved for the construction of tuberculosis sanitaria in suburban Cook County and sufficient state funds have been made available for the 485 bed Chicago State Tuberculosis Sanitarium to be finished this year. Additional beds have been added to Oak Forest Tuberculosis Hospital by rehabilitation of that plant through state funds. Additional beds have been added at the Municipal Tuberculosis Sanitarium in Chicago through improvements and rehabilitation of buildings. Peoria Municipal Tuberculosis Sanitarium has just finished a new addition adding more beds and the Mt. Vernon State Tuberculosis Sanitarium will open around May 1st, 1951. This new 100 bed sanitarium will be fully equipped with surgical facilities, in-sanitarium rehabilitation program, ample recreation space for patients, and full-time medical staff. Dr. Isadore Zapolsky, formerly with the Elgin State Hospital Staff, is the medical director.

Other sanitaria have added new services, such as rehabilitation, medical social service work and other tools to cater to the emotional and social problems of the patient to hasten recovery.

The vigorous legislative program initiated five years ago has been a large factor in improvement of tuberculosis control and this year another program for legislation will be presented to the legislature in Springfield. An original program has had to be curtailed and modified due to lack of funds, and the national emergency, but as this report is being prepared the legislative program agreed upon by those who have studied the need of more beds and services is as follows:

(1) Funds for new construction have been eliminated.	
(2) Operation of Mt. Vernon State Tuberculosis Sanitarium	$ 775,162.00
(3) Operation of Chicago State Tuberculosis Sanitarium	2,918,912.00
(4) State subsidy for the care and treatment of tuberculosis	5,000,000.00
(5) Purchase of equipment for Chicago State Tuberculosis Sanitarium	515,000.00
(6) For activities of the Bureau of Tuberculosis Control	193,122.00
Dropped from the original budget were requests for:	
Construction and furnishing residence at Mt. Vernon	48,000.00
Employees housing at Mt. Vernon	200,000.00
Addition of laboratory and living quarters at Chicago State Sanitarium	580,000.00
Construction of auditorium at Chicago State Sanitarium	475,000.00

The legislative program for 1951 recommended by the legislative committee of the Statewide Committee for the Eradication of Tuberculosis representing 70 agencies cooperating throughout the State and approved by the Tuberculosis Committee of the Illinois State Medical Society is as follows:

(1) Support the revised budget of the Illinois Department of Public Health.

(2) Support permissive legislation to enable medical supervisors of State Tuberculosis Sanitoria to be placed under Civil Service.

(3) Consider amending the school employees examination law to include x-ray examination. (We understand that item 2 was tabled by the Chicago Medical Society Committee).

(4) Increase pegged levy for Chicago from $4½ million to $6½ million.

On November 7, eighteen counties voted the tuberculosis tax law; the following are the counties in which the law passed:

Brown, Cass, Clinton, Crawford, Fayette, Ford, Fulton, Grundy, Jackson, Jefferson, Kendall, Lee, Montgomery, Morgan, Pope, Warren.

The proposition failed in Perry County and Randolph County. An effort to vote out the tuberculosis tax law and close the sanitarium in Woodford County failed.

According to our records, the following counties must vote the tuberculosis tax in 1952:

Douglas, Gallatin, Iroquois, Logan, McLean, Macon, Perry, Randolph, Will.

The counties included above where the tuberculosis tax law is not now in effect may vote the law in 1951 if there is a judicial election during the year. They need not wait for the general election in 1952.

Senate Bill 121 was introduced by Senator Lanz, Woodford County, and amended by Senator Thompson. It passed the Senate with no opposition. Now in the House, it was referred to the Elections Committee on first reading—now out of committee, amended and up for second reading. This bill as amended merely changes the ballot forms of the "Act relating to the care and treatment of persons afflicted with tuberculosis." (Glackin Act) from a "For and Against" type to a "Yes and No" type. This should clarify the proposition for the voters and is a good bill.

House Bill 283—Introduced March 6, 1951, also an amendment to the Glackin Act, provides for the use of sanitarium facilities in other states if no facilities are available in Illinois.

Pollak Hospital, tuberculosis unit of the Peoria State Hospital, was dedicated and placed in operation. This is an outstanding step in the control of tuberculosis in our State Hospitals and the people of Illinois are to be congratulated in this pioneer step. The unit is named for Dr. Maxim Pollak, former superintendent of the Peoria Municipal Tuberculosis Sanatarium, who with the superintendent of the Peoria State Hosptal, Dr. Walter Baer, made the survey of tuberculosis among patients at the institution that led to the building of the hospital so that tuberculosis patients could be isolated from the rest of the hospital population.

The responsibility of the private physician in any program of tuberculosis control can not be overlooked. It is the functional duty of every physician and particularly the family physician to serve as the protector of the health and life of the patient entrusted to his care. A timely suggestion, a word of advice or dispensation of known facts about tuberculosis here and there may be a valuable cog in the eradication of a focus of tuberculosis spread. Additional effort must be continually made to educate the public. Postgraduate courses in tuberculosis that carry a stipend are given by various public health organizations, so that more general practitioners should avail themselves of the privilege of attending one of these courses. Information on these courses is available from various sources or from the chairman of your committee.

The Chicago Medical Society made known to the Tuberculosis Institute of Chicago and Cook County that it desired assistance in the establishing means of educating the doctors on the continued importance of the tuberculosis problem for practitioners. Accordingly, a joint committee was set up with Doctors Hutton and Bornemeier representing the Chicago Medical Society and Dr. Levine representing the Chicago Tuberculosis Society, and Doctors Milan Novak and Block representing the Tuberculosis Institute to make recommendations for educational procedures. This committee met and submitted the following recommendations which are in the process of being worked out:

(1) Submit appropriate material to the Chicago Medical Society Bulletin; such material to be prepared by personnel of the Tuberculosis Institute and approved by the Medical Advisory Committee and to include:

(a) Statistics on tuberculosis deaths to be presented weekly.

(b) Brief selected material from "Tuberculosis Abstracts."

(c) Statistics on case-finding programs for specific areas in Chicago and Cook County.

(d) Short paragraphs of general interest to physicians regarding recent advances and routine information on tuberculosis.

(2) Attempt to introduce into the Chicago daily papers by the same procedure as in (1) above, the following:

(a) Statistics on tuberculosis deaths.

(b) Statistics on case-finding programs in various local areas.

(3) Introduce regularly into hospital staff meetings, formal and informal comments on the problems involved in tuberculosis control and the need for cooperation of general practicing physicians in this program. To this end, the Tuberculosis Institute should:

(a) Constitute a panel of qualified speakers (professional and non-medical).

(b) Attempt to schedule regularly more programs on tuberculosis at hospital staff meetings in the Chicago area.

Many minimal lesions and a limited number of inactive advanced lesions are amenable to outpatient supervision under strict medical care. This supervision and care can often be rendered by the alert general practitioner who possesses modern knowledge of the diagnosis and treatment of tuberculosis.

Tuberculosis real or suspected, is reportable as a communicable disease and we urge that more physicians make it their duty to do this. It is sometimes questionable as to just what should be reported as a "suspect case," but surely frank cases and especially sputum

positive cases should be on record for it is only by getting a report of these cases can the location and source of hidden infections be uncovered. In this way the general practitioner, especially in the smaller communities, can give invaluable aid to those outlining the program of eradication.

Of interest to the family physician who wishes to do tuberculosis testing is the fact that tuberculin is now distributed by the Department of Public Health. Previous dilutions were unstable but that now prepared and sent out is stable and can be stored until used.

Occupational tuberculosis among internes, nurses and other hospital personnel is still a present problem. Besides the increased insurance cost to the hospitals, there is a loss of a skilled worker and hiring and training of a new employee, with a slump in morale in the institution where such a disability from tuberculosis occurs. To quote from the J.A.M.A., "Also there are remote adverse effects which cannot be measured or estimated, such as the effect on prospective candidates for nursing schools when gossip of tuberculosis among nurses spreads among high school girls and their mothers. Hospitals must use the proved method of industrial medicine to combat this occupational hazard. Personnel must have periodic examinations, including roentgenograms and tuberculin tests. All patients must have admission chest films, and records must be kept, both of manifest tuberculosis and of tuberculin conversion in personnel. It must be ascertained when, where and under what conditions disease became manifest or infection occurred. Hospitals in every locality, treating different segments of the population and drawing personnel from various sections, should publish their observations. Effects of control methods must be watched and modified and adapted to the conditions present in the institutions studied. The hospital owes this effort to its employees, to its patients and to those who support it."

If all hospitals, private and public could carry out such a program, one element of tuberculosis propagation would be eliminated.

A new edition of Diagnostic Standards and Classification of Tuberculosis has been published by the National Tuberculosis Association and is available to all physicians. This authoritative booklet is a veritable hand book on terminology, standard tests and classification of this disease. The clinical classification of pulmonary tuberculosis has been simplified and made more useful through a clarification of terms. It comprises a statement of principles and is useful as a general guide. Physicians may obtain this free booklet from their local tuberculosis society, the Illinois Tuberculosis Association, from your Committee or from the Tuberculosis Institute of Chicago and Cook County.

The work of your committee has been very pleasant this year due to the splendid cooperation given by all organizations working with us, and especially the tuberculosis committee of the Chicago Medical Society of which Dr. James Hutton is chairman. Since Chicago is the focal point in the eradication campaign Dr. Hutton and his committee have given great impetus to the work and their contribution has been invaluable. It has been a pleasure to work so intimately with the Illinois Tuberculosis Association, the Department of Public Health, the members of the state legislature, the labor, business and agricultural leaders in the various communities of the State, all working as a unit in the work of eradication. Governor Stevenson is fully informed of the need of the State and has proven very cooperative in furthering the program this past year.

The Tuberculosis Institute of Chicago and Cook County has been ready at all times to give its support in promoting the tuberculosis control program. No reasonable request ever made to this organization was declined.

The Editor of the Illinois Medical Journal has generously inserted paragraphs on tuberculosis which are carefully selected and we urge the members read them for the information they contain.

Respectfully submitted, FRED M. MEIXNER, M.D., *Chairman,* ROBERT K. CAMPBELL, M.D., JAMES H. HUTTON, M.D., OTTO L. BETTAG, M.D., JEROME R. HEAD, M.D., *Committee on Tuberculosis Control.*

COMMITTEE ON VOLUNTARY PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE

Voluntary Prepayment insurance coverage benefiting the people of Illinois for the costs of sickness increased steadily during the last year. A large proportion of the state's population is now covered by voluntary insurance policies for as much of the cost of medical care as it sees fit to purchase.

THE ILLINOIS PLAN—Companies operating under The Illinois Plan were augmented by the entrance of the John Hancock Mutual Life Insurance Company of Boston, Mass., into the field with a policy conforming to the principles established by your committee. That fact gains added importance when it is realized that many "old line" companies such as Hancock have long hesitated to enter The Illinois Plan. It is to be hoped now that other companies, with large sales machinery, will come under The Plan.

The other companies which have been and still are selling Society-approved policies in Illinois are as follows:

1. G. H. Poulsen and Co., 69 W. Washington St., Chicago 2, Illinois, representing the Metropolitan Casualty Insurance Company.
2. The Aetna Casualty and Surety Company, 120 So. LaSalle St., Chicago.
3. North American Accident Insurance Co., 209 So. LaSalle St., Chicago.
4. Illinois Mutual Casualty Company, Peoria, Illinois.
5. Northern Trust Life Insurance Company, Aurora, Illinois.

The Hancock proposal has been approved by legal counsel for the Society, but not formally by your committee as this report is written. It is to be presented to the Committee at its next meeting.

Meanwhile, it is a matter of great satisfaction to your committee to report that, as of December 31, 1950, approximately 350,000 persons in Illinois were covered for medical care expense under policies issued

by the five companies listed in The Illinois Plan. (Hancock was not included on that date.) It is expected that this figure will increase materially through 1951. By far most of the coverage originates with the Metropolitan Casualty Insurance Company.

BLUE CROSS—The Blue Cross protection against the costs of hospital care in Illinois now covers approximately 2,250,000 persons. That figure includes 1,875,000 insured under the Chicago Plan for Hospital Care, 175,000 under the Northern Illinois Plan at Rockford, and 200,000 under the Alton plan. An additional number is insured in the Rock Island area, but the figures are not available.

BLUE SHIELD—Similarly four Blue Shield plans are operating in Illinois—The Illinois Medical Service, Chicago, which also covers some three dozen other counties; the Northern Illinois Medical Service at Rockford; the Blue Shield Medical-Surgical Plan at Alton and the Rock Island County Medical Service. Approximately 490,000 persons were covered by these plans as of March 31, 1951, of whom 451,139 were under Illinois Medical Service. The Illinois Medical Service figure represents an increase of approximately 52,000 since January 1.

The Illinois Medical Service, formerly Chicago Medical Service, is now working energetically toward an enrollment of 1,000,000 persons by January 1, 1952, expanding as rapidly as sound fiscal policy will permit. Recently benefits to subscribers have been increased, including raising of some fees, without increase in premiums.

In each of the counties it now operates in, more than 50 per cent of the medical men have signed agreements to participate. A few weeks ago a sentence in the agreement which had been interpreted as limiting fees to the amount scheduled and which had served to prevent a number of counties from accepting the plan, was reworded for clarification and it is expected that many counties hitherto unreceptive to the plan will now see fit to participate.

Recently the entire membership of an important Chicago labor union—usually considered as in favor of national compulsory sickness insurance—subscribed to Blue Cross and Blue Shield, and several other similar groups are considering such action. That is an important development, for it is from top level labor leaders that proponents of socialized medicine draw much support.

HEALTH IMPROVEMENT ASSOCIATIONS. The Chicago Blue Cross Plan is carrying out an energetic program of establishing health improvement associations in various counties throughout Illinois. These associations are operated on a membership basis, which includes group coverage by Blue Cross, but they also function as health councils, such as are recommended for every county by the Illinois State Medical Society. There are now 34 of these health improvement associations covering 35 counties, including Cook, and many of them have already recorded important achievements in improving the general health protection machinery of their communities. This is a worthwhile activity which should be encouraged by every county medical society.

PRIVATE INSURANCE COMPANIES—There is one other factor of great importance in the voluntary insurance picture of Illinois, long appreciated, but never covered in these annual reports because dependable figures were lacking. We refer to the private insurance companies issuing hospital, surgical and medical care policies. These policies are not specifically approved by your committee, because the companies have never submitted them for approval. They are, however, issued by great companies and they carry out the basic principle of the medical profession's stand in favor of voluntary insurance.

Recently, however, a report, "Health Insurance Provided by Insurance Companies," was submitted by insurance company associations to the Senate Committee on Labor and Public Welfare. The following paragraphs present data taken from that report:

A very large number of persons, insured primarily or as dependents in Illinois as of December 31, 1949, are covered by insurance companies *exclusively* (not Blue Cross or Blue Shield) for hospital, surgical and medical care expense, as shown by figures selected from the national table by states on Page 21 of the report:

	Primary	*Dependents*	*Total*
Hospital	1,617,000	1,614,000	3,231,000
Surgical	1,166,000	935,000	2,101,000
Medical	157,000	65,000	222,000

These figures obviously cannot be totalled vertically. Some policies cover all three forms and many cover both hospital and surgical, so that such totals would be misleading, but the horizontal totals are impressive. When added to the Blue Cross figures given above, they mean that *nearly* 5,500,000 *persons* or about 63 per cent of the 8,700,000 people in Illinois have hospital coverage while *nearly* 2,600,000 *persons* or about 30 per cent have surgical coverage.

Equally impressive are the national totals from the same table:

	Primary	*Dependents*	*Total*
Hospital	14,698,000	13,271,000	27,969,000
Surgical	12,623,000	10,072,000	22,695,000
Medical	2,950,000	1,569,000	4,519,000

The table also shows that the Illinois figures for hospital coverage for both primary insured persons and dependents are the highest in the nation. The total for surgical coverage of primary beneficiaries is second only to New York, which has 1,231,000, while that for surgical coverage of dependents is again highest. It will also be noted that the hospital coverage in Illinois represents about 11.5 per cent of all such business written by private companies in the nation, while the surgical coverage represents about 9 per cent, though Illinois' population is about 6 per cent of the national total.

Another interesting table (Page 52) classifies 169 insurance companies covered by the report according to the decade in which they first began to offer policies carrying various health expense benefits. Of 153 companies selling hospital cost policies, 58 began in 1931-40 decade and 71 in 1941-50. Of 144 companies offering surgical coverage 56 began in 1931-40 and 72 in 1941-50.

Of 96 providing medical coverage, 24 began in 1931-40 and 65 in 1941-50.

Still a third tabulation (Page 13) shows that the hospital care coverage by private companies rose nationally from 14,315,000 in 1946 to 32,426,000 in 1949, surgical coverage from 10,661,000 to 24,905,000 and medical coverage from 867,000 to 5,086,000. (These figures are not adjusted for duplication and hence do not agree with those cited above).

These figures, selected from a 140-page compilation, carry several important implications. They show with certainty for the first time that voluntary insurance protection in Illinois is much more extensive than had been previously appreciated. They indicate that the intense effort of the medical profession in the last two decades, but especially since the Murray-Wagner-Dingell Bill of 1945, have borne fruit, not only in the defeat of the various socialization bills, but also in increasing public appreciation of the importance of voluntary health insurance and hence the amount of such insurance. The huge increases of the last five years are especially significant.

The figures indicate further that the public, once convinced and given opportunity to buy, is able and willing to take care of itself for the most part.

They indicate finally that the public does not feel any compelling need to insist in 100 per cent coverage for its health care cost risks, any more than it does in fire, theft or auto insurance, but is content with that amount of insurance which it can afford and which is also sufficient to take most, not all, of the load of health care costs.

These and other figures from the report are especially gratifying to your committee, since they corroborate the basic policy laid down by the committee when it was established several years ago. By that policy we have never sought to exclude any legitimate type of voluntary insurance. It was our conviction that such an attitude would produce the maximum coverage of the greatest number of individuals in Illinois in the shortest possible time. We believe that is what is happening in Illinois.

AMERICAN MEDICAL ASSOCIATION'S CORRELATING COMMITTEE—The Council on Medical Service of the American Medical Association has established a correlating committee on voluntary insurance to which your chairman was appointed, as recorded in our last report. Among other activities of the committee was the elaboration of a clear definition of medical care as distinguished from hospital care. That definition was accepted by the House of Delegates of the American Medical Association at its recent meeting (December, 1950) in Cleveland.

CONCLUSION. Your committee believes that this report, carrying as it does the figures from the insurance company report, is the most favorable it has yet been our privilege to present to the House of Delegates. More and more voluntary insurance is still the most effective bulwark we have against the sinister forces pressing for the socialization of medicine and certainly Illinois has come a long way since 1945.

Nevertheless, there is still plenty of opportunity to strengthen our position and your committee asks every member of the Illinois State Medical Society to do everything in his or her power to persuade more and more people to seek insurance coverage against the costs of ill health.

Respectfully submitted, PERCY E. HOPKINS, M.D., *Chairman,* WARREN W. FUREY, M.D., *Vice-Chairman,* EDWIN S. HAMILTON, M.D., JACOB E. REISCH, M.D., DAVID B. FREEMAN, M.D., WALTER C. BORNEMEIER, M.D., W. H. PALMER, M.D., *Ex-Officio:* HARRY M. HEDGE, M.D., CHARLES P. BLAIR, M.D., HAROLD M. CAMP, M.D., *Advisory:* JOHN W. NEAL, JAMES C. LEARY, *Committee on Voluntary Prepayment Plans for Medical and Surgical Care.*

COMMITTEE TO INVESTIGATE PRIVATE PRACTICE OF FULL TIME EMPLOYEES OF GOVERNMENTAL AGENCIES

The Committee appointed by the Council to investigate private practice of full-time employees of governmental agencies as recommended by the House of Delegates at the 1950 meeting concluded their work and wish to submit their report.

The Committee gave this problem considerable thought and they were of the opinion that there was no great state-wide problem. The incident that brought about the resolution before the House of Delegates at the 1950 Meeting has been taken care of at the County level. The feeling of the Committee was that these problems could be handled satisfactorily at the County level in most instances and that no definite policy need be established at this time by the State Medical Society.

The Committee will be very glad to continue the study of this problem if the Council or House of Delegates so desires.

Respectfully submitted, CHARLES ALLISON, M.D., *Chairman,* WALTER H. BAER, M.D., DAVID B. FREEMAN, M.D., *Committee to Investigate Private Practice of Full-Time Employees of Governmental Agencies.*

REPORT OF THE WOMEN'S AUXILIARY

As President of the Woman's Auxiliary to the Illinois State Medical Society, I wish to submit the following report:

1. MEETINGS:

Three meetings of the Board of Directors of the Woman's Auxiliary to the Illinois State Medical Society have been held this year. These include the Post Convention Board Meeting, the November and the March Board Meetings. A Pre-Convention Board Meeting will be held May 21st, 1951 in Chicago. A special School of Instruction for County Presidents and Presidents-Elect was held Wednesday, November 15th, preceding the November Board Meeting on November 16th. This extra School and Conference have proven very helpful, and it has been requested that one be held annually in conjunction with the Fall Board Meeting. The President has had full and effective co-

operation of all officers, both State and County, in carrying out the work of the Auxiliary.

2. ORGANIZATION:

Three new Auxiliaries have been organized this year, comprising four Counties, namely:

Jefferson-Hamilton—organized July 13, 1950.

Champaign—organized September 21, 1950.

Kankakee—organized February 8, 1951.

As Whiteside-Lee Medical Societies are separate units, it is the wish of the Medical Societies that there be an Auxiliary to each. Therefore, as of April 12, 1951, there will be a Woman's Auxiliary to Whiteside County Medical Society and a Woman's Auxiliary to Lee County Medical Society.

Six new Members-at-Large have been added. The Auxiliary now has thirty-four (34) organized Counties and Members-at-Large in twenty-one other Counties. Five (5) Counties which do not have an Auxiliary have members affiliated with neighboring County Auxiliaries. This gives a representation in sixty (60) Counties, with a total membership of 1950, an increase of 304 over last year.

It is most gratifying to see the growing interest among Doctors' wives in Auxiliary membership.

The Auxiliary wishes to thank the Councilors of the State Society and the Presidents of the County Medical Societies for their help and interest—without their help, organization would be impossible.

3. BENEVOLENCE:

The Auxiliary is proud to announce that the Treasurer has sent a check for $2,337.09 to Dr. Camp. This contribution to the Benevolence Fund is smaller than last year; however, it represents only $851.00 from Cook County, of $1.00 per member, and the total will be greatly increased when Cook County makes its final contribution before the close of the year in May. The contributions from downstate Counties show an increase over last year. Great interest in the fund is shown in all the Counties.

4. PUBLIC RELATIONS:

The Auxiliary feels to be one of our most important phases of work. In all Counties, Public Relations meetings were held and well received. Perhaps the outstanding one was that of Cook County Auxiliary, with an attendance of more than 700.

"Get Out The Vote" campaigns were launched in every County at the request of the A. M. A. Most of the door bells of Metropolitan Chicago, as well as downstate, were rung by our members, asking eligible voters to register so they might vote on November 7th.

Civil Defense meetings were held to acquaint ourselves and others on "How to Survive an Atomic Attack," and "What We should know About Biological Warfare."

The State Public Relations Chairman, working with the Public Relations Chairman of the State Medical Society, sent questionnaires to our entire membership to determine the skills available for Civil Defense in the event of an emergency.

Two large School Health Programs, one in Springfield and one in Chicago, were actively participated in by Auxiliary members.

At the request of Mary McGinn Taylor of Whitaker & Baxter, letters were sent to all Counties, asking the Auxiliary members to use their influence in recommendations and resolutions against Compulsory Health Insurance in the P.T.A., A.A.U.W., A.N.A., and League of Women Voters. Three County A.A.U.W. groups, Crawford, Vermilion and Sangamon, have passed resolutions by overwhelming majorities, because of the influence and interest of Auxiliary members.

Seven County Auxiliaries have active Nurse Recruitment Programs and furnish Nurse Scholarships or loans. Cook County is beginning a large Nurse Recruitment Program, which should go far toward filling the Illinois requirements for Student Nurses.

Our Auxiliary members are very active in Civic health projects, Blood Bank, Nurses Aids, sending under-privileged children to camps, and assisting in orphanages and homes. We feel that our interest and help in community health and civic projects is good Public Relations.

5. LEGISLATION:

This year has found this department a busy one. All County Presidents and Board Members were placed on the mailing list to receive Dr. Lawrence's "Capitol Clinic" letters.

Thousands of copies of literature have been distributed; Sangamon County Auxiliary handed out over 40,000 at the State Fair alone.

Medical Interest bills, both State and National, have been studied, and many letters and cards have been sent, opposing Compulsory Health Programs.

6. TO-DAY'S HEALTH (formerly Hygeia):

This authentic health magazine has been placed in schools, libraries, waiting rooms, hospitals and a concerted effort was made toward the goal of "To-day's Health in every Physician's Office" and "Every Auxiliary Member a Subscriber."

7. SCHOOL OF INSTRUCTION:

Three Schools of Instruction were held this year in Aurora, Peoria (for all County Presidents and Presidents-Elect) and Chicago (a large School to be held June 5th, 1951).

8. MEDICAL HISTORY:

The Auxiliary has continued with the work of filling out history blanks which pertain to deceased Doctors. We have been glad to assist in this work.

9. NEWS PUBLICATION:

On January 31st, 1951, the first Auxiliary News Publication went to press, under the heading "What's My Name?" Twenty-five hundred copies were printed, addressed and mailed, at a total cost of one hundred and sixty-five dollars and twenty-eight cents ($165.28).

It is hoped to print this publication quarterly, so the next three issues will cost $20.00 less, as the mailing permits are good until January 31st, 1952.

10. PRESIDENT:

As President, I have, or will have visited before the Annual Meeting in May, all the organized Counties in the State, except Livingston. It is my hope to reactivate Livingston County.

I have visited Aux Plaines Branch of Cook County, and organized Jefferson-Hamilton and Champaign, and spoke before the newly organized Kankakee County.

The Annual Convention of the Woman's Auxiliary to the American Medical Association held in San Francisco in June, 1950, was attended, as well as the Seventh Annual Conference for State Presidents and Presidents-Elect held in Chicago in November, 1950.

As President, on behalf of the Auxiliary, I wish to thank Dr. Harry Hedge, President, Dr. H. Kenneth Scatliff, Chairman of the Advisory Committee of the Illinois State Medical Society, and Committee Members, Dr. Harold M. Camp, Dr. E. G. Beatty, Dr. Walter Bornemeier and Dr. C. Paul White, for their encouragement throughout the year, and for selecting a name for our News Publication. It has been a pleasure to work for and with them.

The members of our organization keep in mind that the word Auxiliary means "To Give Aid" and we earnestly want to be informed, willing and ready at all times to live up to our name and give aid to the Illinois State Medical Society in whatever endeavor they may assign to us.

Respectfully submitted, EFFIE S. SIBILSKY, (Mrs. Carl E. Sibilsky), *President, Woman's Auxiliary.*

THE PRESIDENT: The Secretary tells me there is no unfinished business, so we will proceed to new business and the first item will be the introduction of resolutions.

DR. WALTER C. BORNEMEIER, Chicago: I wish to introduce two resolutions.

1. *Sales Promotion Methods Used by Pharmaceutical Houses*

Whereas, the Press Relations Committee of the Chicago Medical Society has received many complaints relative to the sales promotion methods used by some of the pharmaceutical houses through the press, radio and television, and

Whereas, their appeal is directed in many instances to the public, by-passing the medical profession and disregarding established standards,

Be it resolved, that the Chicago Medical Society record its objection to these practices and direct that copies of this resolution be sent to all metropolitan press, radio and television services and that the Editor of the Journal of the American Medical Association comment on the same, ,and

Be it further resolved, that the delegates of the Chicago Medical Society to the Illinois State Medical Society present this matter to the Illinois State Medical Society, requesting it to take cognizance of this situation and bring the same to the attention of the American Medical Association for appropriate action looking to the correction of this situation.

2. *Relief from payment of dues in the American Medical Association by retired and emeritus members*

Whereas, many component county and several constituent state medical societies have classes of non-dues paying members, such as retired and emeritus, and

Whereas, some such members have been relieved of dues because of disability and loss of income, and

Whereas, other members have been relieved of dues because of advanced age, because of long and honorable membership in organized medicine, and

Whereas, the recent action of the House of Delegates of the American Medical Association in adopting dues for all members except in hardship cases, and

Whereas, such membership dues are a hardship in many cases of retired members, and

Whereas, such membership dues do retract from the honor and distinction accorded emeritus and like members,

Therefore be it resolved, that the House of Delegates of the Illinois State Medical Society be urged to present a resolution to the American Medical Association at their annual meeting, recommending that the Constitution and By-laws Committee of that body arrange for classes of membership for both retired and emeritus members with relief from payment of dues in the American Medical Association.

DR. W. O. THOMPSON, Chicago: I wish to present the following resolution:

3. *Opposition to Federal Subsidy of Medical Schools*

Whereas, as Federal subsidy of medical schools as commonly understood would be an important step in federal control of the supply of doctors and therefore promote the political control of medicine, and

Whereas, as the medical profession is well aware of the financial plight of the medical schools, and

Whereas, as important steps are now under way by the American Medical Association and industry to make up the deficits of medical schools,

Therefore be it resolved, that the House of Delegates of the Illinois State Medical Society go on record as supporting the stand of the American Medical Association and as being opposed to Federal subsidy of medical schools.

This resolution is presented by the Committee on Medical Education and Hospitals.

DR. L. S. REAVLEY, Sterling: I wish to present the following resolution:

4. *Salaries Paid to Physicians in the Illinois Department of Public Health*

Whereas, the schedule of salaries paid to physicians employed by the Department of Public Health of the State of Illinois is extremely low, Illinois ranking thirteenth in the table of salaries paid by the various states of the United States, and

Whereas, Illinois, on the other hand, ranks fourth in salaries paid sanitary engineers, fifth in those paid laboratory workers, seventh in those paid public health nurses and second in those paid to vital statisticians, and third in those paid dentists, and

Whereas, the extremely low level of salaries paid to physicians has made it impossible to recruit sufficient physicians to maintain a fitting level of service for the welfare of the people of Illinois, and

Whereas, the rate of recruitment is falling off rapidly to a point where two physicians are lost for every new one hired, so that the only prospect for the future is a definite further deterioration of the quality of service rendered by the department to the people of Illinois because of the shortage of physicians,

Now, therefore, be it resolved, that the House of Delegates of the Illinois State Medical Society hereby request the General Assembly and the Governor of Illinois to take immediate steps to raise the level of salaries paid the physicians in the Illinois Department of Public Health.

5. *Clearance for radio and television programs.*

DR. CHARLES H. PHIFER, Chicago: This resolution has to do with radio and television programs throughout the country. More and more physicians are appearing on these programs without the approval of the Society. Last year a resolution was introduced by Dr. C. Paul White. It was approved by the House of Delegates. During the year your Educational Committee and Committee on Medical Service were confronted with the fact that still many men appear on radio and television without approval of the Society. We are having the same problem in the A.M.A. During the year Dr. Blair referred this problem to the Ethical Relations Committee and we, in turn, discussed it with the Constitution and By-Laws Committee, and we thought, too, that this resolution introduced by Dr. C. Paul White last year and approved by the House should be re-introduced this year and probably more teeth put in it.

Whereas, physicians in Illinois frequently are asked to discuss health and medical care over radio and on television, and

Whereas, an increasing number each year are asked to present subjects, such as medical care under a compulsory system, and

Whereas, a physician so appearing speaks not only as an individual but as a representative of the 10,000 members of the profession who compose the Illinois State Medical Society,

Therefore be it resolved, that the House of Delegates of the Illinois State Medical Society in session on this 23rd day of May, 1950, do hereby urge that all physicians discussing matters of health and medical care especially over radio or on television programs, first obtain for themselves and the subject matter to be presented, ethical clearance from the Educational Committee or the Committee on Medical Service and Public Relations of the Illinois State Medical Society before making their broadcast.

DR. ALLISON BURDICK, Aux Plaines Branch: I wish to present the following resolution:

6. *Relief from full payment of dues, local, state and A.M.A.*

Whereas, there are members of the local branches of the medical societies throughout the state who experience varying degrees of hardship in paying their local, state and A.M.A. dues or who, for various reasons, desire to partially retire from their participation in medical society activities, and

Whereas, there is no provision at the present time whereby these persons may pay a portion of their dues and still remain in good standing,

Be it resolved, that the Aux Plaines Branch of the Chicago Medical Society requests the Illinois State Medical Society and in turn the American Medical Association to give this matter their earnest consideration, and

Be it resolved, that the suggestion be made to the Chicago Medical Society and in turn to the upper level organizations, that committees be established in the local medical societies to receive requests from these persons and to pass on the merits of the individual case, making recommendations to the central organizations regarding the proper amount of dues to be paid in each specific instance in accordance with a scale agreed upon by the central organizations.

DR. LEO P. A. SWEENEY, Chicago: I have a resolution to present.

7. *Support of H.B. 311 (The Illinois Civil Defense Bill)*

Whereas, The Committee on Military Affairs and Emergency Medical Service of the Illinois State Medical Society, through its work with the Illinois Office of Civil Defense, particularly in the preparation of Annex V to the Illinois State Civil Defense Plan, has become acquainted with the health resources of the State of Illinois and the demands in terms of enormous numbers of casualties and other health problems which may be placed upon such facilities and personnel by enemy attack, and

Whereas, the present state defense legislation (The Illinois War Council Act of April 17, 1941) is wholly insufficient to meet possible demands of defense against atomic bombs, rockets and other special weapons, and

Whereas, H.B. 311 (The Illinois Civil Defense bill) has been specifically designed to meet the needs for civil defense created by modern warfare techniques.

Now, therefore, be it resolved: 1. That the House of Delegates of The Illinois State Medical Society go on record favoring the passage of H.B. 311 as amended to include (a) the consent of owner of property prior to the State's acquisition of such property for emergency purposes, and (b) the establishment of a committee of the General Assembly of the State of Illinois to pass on interstate mutual aid pacts when the General Assembly is not in session, and

2. That the House of Delegates of the Illinois State Medical Society recommends that the members of the Illinois State Medical Society become interested actively in civil defense in their home communities and seek by every means to stimulate professional and public interest in this legislation, which has potential far-reaching significance for the health and safety of the people.

DR. JOHN UBBEN, Staunton: I have a resolution from Macoupin County.

8. *Misrepresentations by The St. Louis Post-Dispatch in Reference to the position and purposes of The Macoupin County Medical Society and The Illinois State Medical in the matter of the Community Memorial Hospital at Staunton.*

Whereas, The Macoupin County Medical Society in recent months has been the journalistic target of the St. Louis Post-Dispatch in a number of slanderous articles directed at the society for disapproving a proposed cooperative hospital plan incorporating the hiring of physicians on a salaried basis; and

Whereas, the physicians of the Macoupin County Medical Society feel that our reputations have been maligned and our position inaccurately presented:

Now, therefore, be it resolved, 1. That we present our side of the case in the following resolution, and

2. That the Illinois State Medical Society approve our stand in the matter.

The Macoupin County Medical Society
Frank B. Warner, M.D., President
Joseph J. Grandone, M.D., Secretary

Resolution

Whereas, The St. Louis Post-Dispatch has unfortunately on numerous recent occasions misrepresented the position and purposes of The Macoupin County Medical Society and The Illinois State Medical Society in the matter of the Community Memorial Hospital at Staunton, Macoupin County, Illinois; and

Whereas, the position and purposes of The Macoupin County Medical Society and The Illinois State Medical Society are those dictated by principles of medical ethics proven through long experience, and by the law of the State of Illinois, equally valid and justified, by both of which The Macoupin County Medical Society is bound willingly; and

Whereas, The St. Louis Post-Dispatch, in spite of these predominant considerations, asserted in an editorial that the physicians of Macoupin County "prevented" the opening of the said hospital because its plan for "prepaid preventive medical care" would have "affected Macoupin County doctors' pocketbooks"; and

Whereas, The St. Louis Post-Dispatch has never made it clear that The Macoupin County Medical Society has never in any way sought to "prevent" the opening of the hospital and omitted also to point out that, right or wrong, the Society is bound by its ethics and the law of Illinois; and

Whereas, The Staunton Community Memorial Hospital was projected as a medical care and insurance cooperative, in which physicians would be employed on salary paid by the hospital in violation of medical ethics, without consultation with The Macoupin County Medical Society as such concerning the plans for the hospital, especially its medical staff; and

Whereas, several attempts were made to engage for a salary ethical physicians, members of The Macoupin County Medical Society, all of whom rejected the offers because of the impropriety of the conditions of employment; and

Whereas, the law of the State of Illinois requires that 51 per cent of the physicians of the area to be served must sign agreements to participate in any plan to provide voluntary prepayment insurance against the cost of medical care before it can become operative, a wise provision to ensure the success of any such plan; and

Whereas, because of the peculiar nature of the hospital plan, and because no request for such agreement to participate was presented to The Macoupin County Medical Society, no such proportion of the physicians ever signed such an agreement; and

Whereas, the physicians of Macoupin County, even had the plan been ethical, would have been acting entirely within their legal rights in remaining aloof from the plan; and

Whereas, since the hospital was refused federal and state funds and did not appear necessary as indicated by The Illinois Survey and Plan; and

Whereas, the individual physicians of Macoupin County, far from objecting to the establishment of the hospital, nevertheless contributed substantial sums in the campaign to raise funds to complete rehabilitation of the building; and

Whereas, after completion of the building, the proponents of the plan, apparently unable to hire physicians under their proposed unethical and illegal plan, finally approached The Macoupin County Medical Society for aid in staffing the hospital, and the Society through a special committee made a thorough investigation and on June 13, 1950, in writing, notified the hospital board that it would not "approve the cooperative plan of professional services as proposed" and in the same letter offered to meet the hospital board at any time to discuss any favorable changes that might be made in the plan;

Whereas, The Macoupin County Medical Society at a special meeting August 17, 1950, furthermore proposed that the hospital program be altered to provide free choice of physician by patient and determination of fees by the fee schedule of the Society, and recommended that prepayment insurance through Blue Cross-Blue Shield plans available throughout the state be studied; and

Whereas, these proposals were finally accepted by the board of trustees of the Community Memorial Hospital, and a proper and legal medical staff consisting of twenty-two physicians was immediately organized and is now serving the patients in the hospital;

Now, therefore, be it resolved

1. That The Macoupin County Medical Society, in the sincere belief that it has acted entirely in accordance with sound medical ethics and the law of Illinois, expresses its regret and disappointment that a newspaper of the journalistic quality and reputation of The St. Louis Post-Dispatch has suffered itself to be misled into presenting physician members of the Society as greedy, monopolistic, and inconsiderate of the community welfare; all of which charges are implicit in articles and an editorial published on the matter in that paper in recent months.

2. That The Macoupin County Medical Society hopes the editors of The St. Louis Post-Dispatch will take whatever steps are necessary to correct the erroneous impression created by the said news stories and to see that they are not again repeated, and will, in accordance with sound journalistic ethics, seek henceforth to present both sides of this controversy impartially, keeping its news columns free of editorial bias, that it may retain the respect it now enjoys as a great newspaper.

3. That a copy of this resolution, signed by the president and secretary of The Macoupin County Medical Society, be sent by the Secretary to the managing editor of The St. Louis Post-Dispatch.

4. That our delegates to the annual meeting of The Illinois State Medical Society, to be held in Chicago

May 22-24, 1951, be directed to present a signed copy of this resolution to the House of Delegates of the Society with a request that the Society approve our stand in this matter.

The Macoupin County Medical Society
Frank B. Warner, M.D., President
Joseph J. Grandone, M.D., Secretary

Approved May 8, 1951.

DR. E. W. WELD, Rockford: I wish to present the following resolution:

9. *Disapproval of any practice of medicine by industry that might destroy physician-patient relationship.*

Whereas, a pleasant physician-patient relationship is the greatest weapon that the medical profession has to oppose socialized medicine, and

Whereas, for industry to practice medicine would, we believe, jeopardize this relationship,

Therefore be it resolved, that the Winnebago County Medical Society disapprove of any practice of medicine by industry that might in any way destroy this physician-patient relationship,

Be it further resolved, that the House of Delegates of the Illinois State Medical Society, be requested to endorse a similar resolution, and

Be it further resolved, that the Delegates of this Society be instructed to present this resolution to the House of Delegates at the annual meeting of the Illinois State Medical Society in Chicago, Illinois, on May 22, 1951.

E. H. Weld
J. H. Maloney
L. S. Greenwood

DR. E. H. WELD, Rockford: I have a second resolution from the Winnebago County Medical Society.

10. *Medical Benevolence Fund: The Substitution of a "Pay-as-you-go" Plan in Place of the Present Endowment Fund.*

Whereas, the Medical Benevolence Fund of the Illinois State Medical Society, established in 1940, is recognized as a worthy and laudable responsibility and as a cohesive force within the Society which should be continued, and

Whereas, during the ten (10) years of its existence the Fund has cared for approximately, sixty (60) beneficiaries at the cost of nearly $40,000, and

Whereas, the present economic confusion in our country today, and good common sense, proves that a "pay-as-you-go" plan provides a sounder basis,

Therefore be it resolved, that the Winnebago County Medical Society disapproves of the accumulation of a Benevolent Fund of some four hundred to five hundred thousand dollars which would take from twelve to fifteen years to become self-sustaining,

Be it further resolved, that the House of Delegates of the Illinois State Medical Society be emphatically requested to amend its By-Laws and to substitute a "Pay-as-you-go" plan in place of a self-sustaining Endowment Fund, and

Be it further resolved, that the Delegates of this Society be instructed to present this resolution to the House of Delegates at the Annual Meeting of the Illinois State Medical Society in Chicago, Illinois, on May 22, 1951.

E. H. Weld
J. H. Maloney
L. C. Greenwood

THE PRESIDENT: Other resolutions may be given to the Committee during the interim between now and Thursday. As there is no further business, I shall entertain a motion to adjourn.

DR. WILLIAM DYKO, Chicago: I move we adjourn. (Motion seconded by Dr. J. J. Moore, Chicago, and carried).

The House adjourned at 5:05 P.M. to meet again on Thursday morning at nine o'clock.

IN THE AUGUST ISSUE—

Pictures of the Annual Meeting

NEWS OF THE STATE



ADAMS

Society News.—Dr. Franklin E. Walton, associate professor of clinical surgery, Washington University School of Medicine, St. Louis, discussed "Acute Surgical Pediatric Emergencies" before the Adams County Medical Society recently.

Personal.—Dr. Harry G. McGavran is president of the Exchange Club of Quincy for the current year.—Dr. James H. Cravens, Quincy, was recently certified by the American Board of Pediatrics.

COOK

Gift for Study on Multiple Sclerosis.—A gift of $25,000 was presented to Northwestern University May 31 by Harry Abrahams, founder of the Multiple Sclerosis Foundation. The presentation was made to Dr. J. Roscoe Miller, president of the university.

Grants for Research.—Two Chicago firms have awarded grants to the University of Illinois College of Medicine in support of research investigations.

The Lakeland Foundation has renewed a grant in the amount of $7,000 for the study of a cancer diagnostic test.

Abbott Laboratories has contributed $1,000 for an investigation concerning the effect of amines on high blood pressure in experimental cases.

Results of Essay Contest.—Winners in the annual essay contest among interns and residents of Chicago hospitals, sponsored by the North Shore Branch of the Chicago Medical Society, were: First prize to Dr. Robert K. Jones, "Increased Intracranial Pressure Following Radical Neck Surgery"; second to Dr. Donald Johns, "Respiratory Obstruction in Early Infancy"; third, Dr. Howard S. Traisman, "The Use of Desoxycorticosterone Acetate in Dehydration and Malnutrition in Infancy"; and fourth to Dr. Hyman S. Lans, "The Occurrence and Treatment of Potassium Deficiency in Surgical Patients." The awards were $150 for the first winner; $100 for the second; $50 for the third and $25 for the fourth.

The Gehrmann Lectures.—The Gehrmann Lectures featured an assembly hour at the University of Illinois College of Medicine recently. Dr. Thomas Francis Jr., professor and chairman of the department of epidemiology, University of Michigan School of Medicine, Ann Arbor, discussed "Epidemiologic and Serologic Variations in Influenza Virus" and "Evaluation of Vaccination Against Influenza." The lectureship was established in memory of Dr. Adolph Gehrmann who for many years was professor of bacteriology at Illinois and its predecessor institution, the College of Physicians and Surgeons of Chicago. The lectureship was endowed by the Gehrmann family to perpetuate Dr. Gehrmann's name.

Special Society Elections.—Dr. Craig D. Butler, Oak Park, was chosen president of the Chicago Pediatric Society at its recent annual meeting. Other officers are Dr. George F. Munns, vice president; Dr. Maxwell P. Borovsky, treasurer; Dr. Alfred S. Traisman, secretary and Dr. Ralph H. Kunstadter, editor.—At the annual meeting of the Chicago Urological Society recently Dr. Frederick Lloyd was elected president, Dr. J. S. Grove, vice president and Dr. Joseph H. Kiefer, treasurer.

Helga Ruud Honored.—The Woman's Auxiliary of the Norwegian American Hospital honored Dr. Helga Ruud recently at a benefit card party and fashion show. Dr. Ruud had served on the staff of the hospital for forty-seven years. She is also a charter member of the auxiliary.

Personality of the Week.—Dr. Robert H. Mitchell was chosen as "This Week's Personality by the Park Ridge Herald in a recent issue. Dr. Mitchell

graduated at the University of Indiana School of Medicine in 1943 when he went into active service in the Army. He is a member of the Park Ridge Kiwanis Club and post surgeon of the Veterans of Foreign Wars.

Society News.—Dr. Manuel E. Lichtenstein addressed the Yellowstone Valley Medical Society May 27 on "Colostomy—A Classification of Types and Indications for Each", and on "The Causes for Poor Results Following Cholecystectomy and Their Prevention", May 28.

Personal.—Dr. Irene Josselyn has been named medical director of a mental health clinic which is being established by the North Shore Mental Health Association.—Dr. William J. Dieckmann, and Dr. H. Close Hesseltine, Chicago, were recently presented with gold pins signifying twenty years of service to the staff of Chicago Lying-In Hospital.

New Head of Internal Medicine.—Dr. Harry F. Dowling has been appointed as professor and head of the department of internal medicine at the University of Illinois College of Medicine, Dean Stanley W. Olson has announced.

Dr. Dowling will assume the position on Sept. 1. He will succeed Dr. Robert W. Keeton, who will retire from active service at the end of the current academic year.

The department of internal medicine is one of the major departments in the College of Medicine. At present, approximately 225 physicians hold appointments in this department.

Dr. Dowling presently serves as professor and head of the department of preventive medicine at the University of Illinois. He was appointed to that position a year ago when the department was established.

Italian Physician Awarded Fellowship.—Dr. Giano Magri of Ferrara, Italy, has arrived in Chicago on the Morris Fishbein Jr. fellowship to undertake studies of rheumatic heart disease in children, according to an announcement by President John J. Sheinin of the Chicago Medical School. Dr. Magri will work under the direction of Dr. Aldo A. Luisada, Program Director of Cardiology and Assistant Professor of Medicine at the school. He will divide his time between the school laboratory at Mount Sinai Hospital and La Rabida Sanitorium in Jackson Park which is directed by Dr. Hugh McCulloch and is affiliated with the Chicago Medical School.

Dr. Magri received the degree of M.D. cum laude from the University of Bologna, and was on the staff of the medical school and hospital of Ferrara, Italy.

Course for Bacteriologists.—An intensive summer course for bacteriologists who are interested in gaining laboratory experience in basic techniques in virology will be offered by the University of Illinois Chicago Professional Colleges starting June 25.

The course will be of eight weeks duration, continuing until August 18. It will be given under the direction of Dr. J. E. Kempf, associate professor of bacteriology.

Subjects which will be considered are cultivation of viruses, the preparation of suspensions and tissue sections for observation on the electron microscope, concentration of viruses by several methods including the use of the Spinco ultracentrifuge and the Sharples centrifuge, biological and serological techniques for the isolation and identification of viruses, bacteriophagy, and *in vitro* and *in vivo* inactivation of viruses.

Full graduate credit will be awarded for satisfactory completion of the course. Requirements for admission are a bachelor's degree, basic course work in bacteriology, and qualifications for registration in the Graduate College of the University.

The tuition is $17.50 for residents of Illinois. Applications and further requests for information should be addressed to Dr. Milan V. Novak, Associate Dean of the Graduate College, Chicago Professional Colleges, University of Illinois, 808 S. Wood Street, Chicago 12, Ill.

New Unit for Psychiatry.—On June 2, dedicatory ceremonies were held at Michael Reese Hospital for the new $2,000,000 Institute for Psychosomatic and Psychiatric Research and Training. The five-story building has a capacity of 82 patients and is the first major hospital building for patients to be completed in the long-range enlarged medical center plans of Michael Reese Hospital. Funds for the institute were provided by the Jewish Federation of Chicago; Mr. and Mrs. Albert D. Lasker, New York; Mr. and Mrs. Leigh Block, Chicago; and Mr. and Mrs. Sidney Brody, Beverly Hills, Calif. One-third of the beds will be for service cases, part pay or no pay. There are facilities for research, teaching and care of patients, with about 20 per cent of the space set aside for research. One of the purposes of the institute is the teaching of much-needed trained personnel: resident physicians training to become psychiatrists, medical students, social workers, nurses, occupational therapists, psychologists, interns, residents and staff doctors in other specialties on the Michael Reese staff. The institute has four divisions: the psychosomatic division, the division for psychiatric patients, the division for child care and a special division for disturbed patients. Dr. Roy R. Grinker is director of the institute.

DU PAGE

Society News.—Howard Shaughnessy, Ph.D., deputy-director, division of laboratories, Illinois Department of Public Health, discussed "Control and Preventions of Infectious Diseases in the Civil Defense Program" before the DuPage County Public Health Council recently.

FORD

Society News.—Dr. John T. Reynolds, Chicago, addressed the Ford County Medical Society, recently, on "Advances in Surgery."

FRANKLIN

Personal.—Dr. M. A. Turner has been appointed physician for the Old Ben Coal Corporation, Christopher, to succeed Dr. W. W. Sheerer, who retired. Dr. Sheerer has been practicing medicine in the town since 1905.

JASPER

Personal.—Dr. W. E. Franke, Newton, was recently elected to emeritus membership in the Illinois State Medical Society.

KNOX

Society News.—Dr. D. A. Clark, Chicago, addressed the Knox County Medical Society in Galesburg recently, on "Radioactive Iodine in the Treatment of Carcinoma of the Thyroid."

LAKE

President of Blood Bank Foundation.—Dr. John L. Ward, Lake Bluff, was elected president of the Jacob Blumberg blood bank foundation at a directors meeting in Victory Memorial Hospital, May 15. He succeeds Dr. Paul H. Burgert, Lake Forest, who resigned. The meeting was called by Dr. Hugh Wilson, technical director of the newly organized blood bank which seeks to provide blood through all medical institutions in the county. In outlining the proposed program, Dr. Wilson stated that it is planned to give blood to members and their families at no fee except a minimum service charge. Dr. Donald C. Nellins, president of the Lake County Medical Society, stated that the society has underwritten the program.

LEE

Society News.—Dr. Donald H. Wrork, Rockford, addressed the Lee County Medical Society, recently, on "Pain in the Extremities."

MACON

Society News.—"Ulcerative Colitis" was discussed May 29 by Dr. Robert T. Tidrick, professor of surgery and dean of the University of Iowa College of Medicine, before the Macon County Medical Society.

MADISON

Staff Election.—Dr. Hubert L. Allen was installed as president of the medical staff of Alton Memorial Hospital at a recent meeting, succeeding Dr. Robert B. Lynn. Other officers are Dr. Maybelle Williams, vice president; and Dr. Arthur A. Brewer, secretary-treasurer.

MARION

Society Election.—The following officers of the Marion County Medical Society were recently elected to office: Dr. Edward F. Stephens Jr., Centralia, president; Dr. Harry D. Nesmith, Salem, vice president; Dr. Ben H. Barbour Jr., Centralia, secretary-treasurer; and Drs. Nolan White, H. D. Gillette and Harry Ryan, all of Centralia, councilors. The May meeting of the society was addressed by Dr. Earl Semon. There will be no meetings of the group during July and August. Sessions will be resumed on September 20.

MERCER

Society Election.—The following officers were elected at the annual meeting of the Mercer County Medical Society: Dr. W. A. Miller, Aledo, president; Dr. C. M. Murrell, Sherrard, vice-president; Dr. Benjamin Freiband, Keithsburg, secretary-treasurer. Dr. Martin E. Conway, Aledo, was elected delegate to the Illinois State Medical Society with Dr. Joseph Raimond, New Boston, as alternate.

MORGAN

Golden Wedding Anniversary.—Dr. and Mrs. E. W. Crum, who have been residents of Waverly since 1917, observed their fiftieth wedding anniversary, May 27.

SANGAMON

New Health Officer.—Dr. J. Marvin Salzman was recently appointed health superintendent of Springfield, succeeding Dr. Albert C. Baxter.

SCHUYLER

Staff Election.—Dr. Everett Coleman, Canton, was recently appointed chief of staff of the Culbertson Memorial Hospital in Rushville. Dr. V. M. Corman, Rushville, was named vice president; and Dr. Charles Carey, Rushville, secretary.

VERMILION

Society News.—Dr. I. Pat Bronstein, Chicago, addressed the Vermilion County Medical Society recently on "Pediatric Endocrinology."

GENERAL

Annual Institute on Conservation, Nutrition and Health.—The Tenth Annual Institute on conservation, nutrition and health was held at the Stevens Hotel, Chicago, June 21-23, with the theme: "Health—From the Ground Up." Among the speakers were Ollie E. Fink, Columbus, O., "Objectives of the Institute"; Garth W. Volk, Columbus, "Modern Farming and the Accelerated Deterioration of Soil Structure"; Richard Bradfield, Ithaca, N. Y., "Modern Farming and the Accelerated Deterioration of Soil Fertility"; Charles D. Jeffries, State College, Pa., "The Interpretation and Significance of Soil Mineral Studies"; Paul B. Sears, New Haven, Conn., "The Response of Plants to Moisture"; F. W. Went, Pasadena, Calif., "The Response of Plants to Climate"; George D. Scarseth, Lafayette, Ind., "Soil, Civilization and Our Health"; Vincent J. Schaefer, Schenectady, N. Y., "The Scientific Aspects of Rainmaking"; Edward J. Condon, Chicago, "Objectives of Friends of the Land"; William A. Albrecht, Columbia, Mo., "Reconstructing the Soils of the World to Meet Human Needs"; Louis Bromfield, Lucas, O., "Reconstructing the Farm to Meet Its Individual Needs"; Ruth Griswold, Chicago, "Proper Food Preservation"; Faye W. Grant, Evanston, "Proper Preparation and Serving of Food"; W. Franklin Dove, Chicago, "Food Habits and Food Acceptance"; Jonathan Forman, Columbus, O., "Modern Concept of Disease"; John J. Miller, Chicago, "Soils and Health"; Ancel Keyes, Minneapolis, Minn., "The Biology of Human Starvation"; and Theodore W. Schultz,

Chicago, "Conservation and Food Production in a Hungry World."

Public Health Physicians Choose Officers.—The new officers of the Illinois Association of Medical Health Officers for 1951-1952 were announced following the spring meeting of the association. They are Dr. L. L. Fatherree, Joliet, president; Dr. E. A. Piszczek, Chicago, vice president; Dr. Herbert Ratner, Oak Park, secretary-treasurer; and Dr. S. N. Mallison, Champaign, Dr. Winston Tucker, Evanston, and Dr. A. C. Baxter, Springfield, members, executive committee. The association consists of full-time public health physicians. Its purpose is to consider public health practices and questions relating to practical administration of public health, hygiene and sanitation, to provide consultation to State and local public health agencies, to make recommendations regarding standards, rules and regulations and to undertake such other functions as will promote better public health and public health organization in the State of Illinois.

Tuberculosis Sanitarium Dedicated.—On May 13, Illinois' first-owned tuberculosis sanitarium, located in Mount Vernon, was dedicated. Dr. Roland R. Cross served as master of ceremonies and speakers included Governor Adlai E. Stevenson, Dr. Harold M. Graning, regional director, U. S. Public Health Service, Chicago; Dr. Kenneth G. Bulley, president, Illinois Tuberculosis Association; Dr. Andy Hall, Mount Vernon, former state director of public health; Mrs. Laura Lunde, co-chairman, State-wide Tuberculosis Eradication Committee and Dr. E. A. Piszczek, chairman of the Board of Public Health Advisors to the Illinois Department of Public Health. Invocation was pronounced by the Reverend Mr. Robert B. Guthrie, Mount Vernon Presbyterian Church and the benediction by the Reverend Father James Burke, St. Mary's Catholic Church, Mount Vernon. The new sanitarium has facilities for 100 patients who may be admitted from any part of the state. It will be operated by the state department of Public Health but the cost will be met by a local agency with the responsibility for the care and treatment of tuberculosis patients, as provided by law.

Syllabus for Psychiatric Residency Training Offered by the Department of Public Welfare.—The program as outlined below will offer residents in psychiatry three years of training in approved mental hospitals or other institutions affiliated with the Illinois Department of Public Welfare. This program has been set up so that the resident will be able to fulfill the essential requirements of the training program suggested by the American Board of Psychiatry and Neurology. One and one half years will be spent in state mental hospitals and an additional 18 months will be devoted to the various specialties. The outline for the three year program is as follows:

I. During the year and one half spent at the state hospital, the equivalent of a year will devoted to the diagnosis, study, and treatment of the major psychoses. Arrangements will be made by the clinical director for the resident to spend this time among the following services: receiving service, the acute hospital for medical and surgical illnesses, the infirmaries and semi-infirmaries, the custodial wards and the intensive treatment center. The remainder of the time will be devoted to a coordinated training program arranged by the clinical director in which lectures, supervised conferences, seminars, etc., will be used for teaching the various subjects in psychiatry, including history of psychiatry, the psychoses, the psychoneuroses, psychodynamics, demonstrations in psychopathology, forensic psychiatry and the various therapies. There will also be time devoted to basic and clinical neurology under the direction of the Clinical Director. Time will also be arranged to take part in the out-patient clinics for conditionally discharged patients.

II. The second part of the program consists of 18 months away from the hospital for the various specialties. This period does not necessarily follow the first part of the program as given in I but it is to be expected that the resident will have completed a certain amount of the basic training before being enrolled in part II. The program for this period is as follows:

1. Intensive Psychiatry Illinois Neuropsychiatric Institute Dr. Francis J. Gerty and staff	3 months
2. Intensive Neurology Illinois Neuropsychiatric Institute Dr. Ben Lichtenstein	3 months
3. Juvenile Psychiatry Institute for Juvenile Research Dr. George Perkins and staff	3 months
4. Psychotherapy Veterans Rehabilitation Center and Chicago Community Clinic Dr. David Slight and staff	6 months
5. Institutions for the Mentally Defective (Dixon State Hospital Lincoln State School and Colony)	2 months
6. Forensic Psychiatry Municipal Psychiatric Institute or Cook County Behavior Clinic	1 month
	18 months

ADMINISTRATION

Although psychiatric residents will be assigned to individual hospitals, it is to be understood that any resident who enters training under the above program is to be accepted by the Educational Residency Training Committee. A representative from the office of the Chief Medical Officer will act as a liaison officer between the Department of Public Welfare and the various institutions participating in the program. The Chief Medical Officer and his representative will be responsible for the assignment of the residents to the various services as indicated above. The Educational Residency Training Committee will act as an advisory counsel for the Chief

Medical Officer and the psychiatric residents for any complaints or suggestions, and they may also change the above mentioned program in case of emergency.

DEATHS

Emmet F. Casey, Chicago, who graduated at the University of Illinois College of Medicine in 1916, died May 19, aged 57. He had served in the army medical corps in World Wars I and II.

Clyde J. Chamness, Elkville, who graduated at Chicago College of Medicine and Surgery in 1910, died May 13, aged 63.

Royal L. Eddington, Lacon, who graduated at Barnes Medical College, St. Louis, Mo., in 1912, died May 15, aged 72. He was formerly mayor of Lacon, a member of the Proctor Hospital staff and former coroner of Marshall County.

Charles A. Griffith, River Forest, who graduated at Rush Medical College in 1908, died May 25, aged 71. He had practiced medicine in River Forest since 1909 and since 1934 he had been a director of the River Forest State Bank.

Robert H. Herbst, Highland Park, who graduated at Rush Medical College in 1900, died May 15, aged 73. He was emeritus professor of urology at the University of Illinois College of Medicine.

Nelson H. Lowry, retired, Skokie, who graduated at the Hahnemann Medical College and Hospital in 1910, died May 17, aged 65. He was formerly a staff member at Edgewater Hospital.

Sigmund Mann, Oak Park, who graduated at Chicago College of Medicine and Surgery in 1916, died April 16, aged 65.

Raymond James Murphy, Chicago, who graduated at Loyola University School of Medicine in 1926, died March 2, aged 52.

Ernest Radcliff, Jonesboro, who graduated at Washington University School of Medicine, St. Louis, in 1906, died March 17, aged 74.

Elbert Van der Heyden Rawlins, Roodhouse, who graduated at St. Louis University School of Medicine in 1904, died January 27, aged 76.

Walter A. Stuhr, Chicago, who graduated at Northwestern University Medical School in 1910, died June 5 in Council Bluffs, Ia. He was 70 years of age.

Porter W. Summers, Chicago, who graduated at Bennett Medical College, Chicago, in 1912, died June 8, aged 68.

Harry E. Walsh, Chicago, who graduated at Chicago College of Medicine and Surgery in 1910, died May 16, aged 75. He was a surgeon for the Rock Island Railroad.

Adam L. Yuska, Chicago, who graduated at the University of Illinois College of Medicine in 1911, died May 23, aged 76. He had practiced medicine on the southwest side for 38 years.

CARCINOMA OF THE THYROID GLAND

Sixty-three cases of cancer of the thyroid gland were studied. In 16 cases the cancer arose in an adenoma — without clinical evidence of carcinoma in any instance.

Hoarseness, dyspnea and dysphagia, fixation and hardness, and slow enlargement of the lateral lymph nodes were the most common diagnostic signs and symptoms.

The most common avenue of spread is the lymphatic system. In two-thirds of the cases in which metastasis occurred, the cervical nodes were involved.

Prognosis is related to the histologic type of the lesion.

Of 35 patients observed for five years after treatment, ten had no evidence of disease at the end of that time. Twenty were followed for ten years and four of them apparently were free of cancer.

The trend in treatment is toward more extensive surgical dissection. In inoperable cases, irradiation has been used with some benefit. *Excerpt: Carcinoma of the Thyroid Gland, Robert S. Pollack, M.D., San Francisco, Calif. M., May 1951.*

Lubricoid action WITHOUT OIL

THE CLINICAL EFFECT OF TURICUM® IN CONSTIPATION

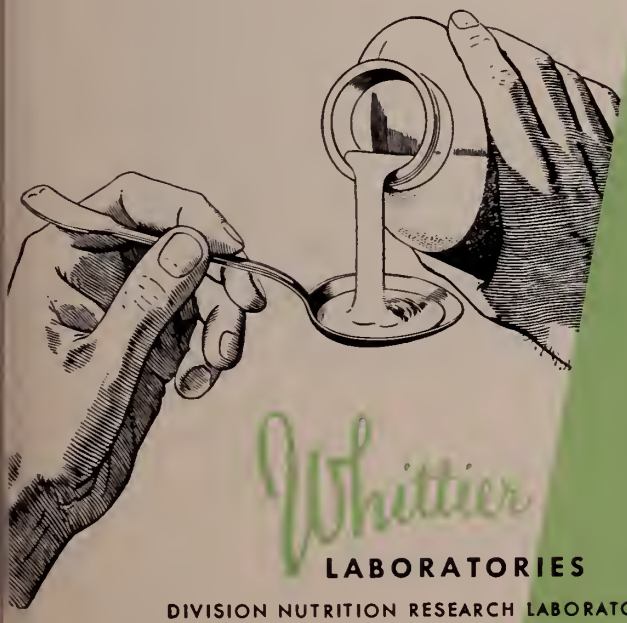
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Armbrust, C. A., Jr., and Levine, S. A.: Am.J.M.Sc. 220:127 (August) 1950	"About 60% of the cases showed improvement; i.e., used fewer nitroglycerin tablets, had fewer and milder attacks of pain and could walk greater distances."
Rosenman, R. H., et al.: J.A.M.A. 143:160 (May 13) 1950	"Of 14 patients with angina pectoris treated with ['Eskel']... a good response was obtained in 11, moderate improvement in 1 and no effect in 2."
Osher, H. L., et al.: New England J. Med. 244:315 (March 1) 1951	"Twenty-six of 32 patients were found to be benefited by ['Eskel'] therapy; ... no serious toxic reactions were encountered."

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Each 'Eskel' tablet contains a natural blend of active principles, chiefly khellin, extracted from the plant Ammi visnaga.

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ANTIHISTAMINE ACTION

with minimum side effects

HISDRIN makes possible full antihistamine effect for prolonged periods, but reduces such complicating side actions as drowsiness or lethargy. Its desirable clinical behavior is due to a rationale combination of a dependable antihistamine agent and a sympathomimetic drug which exerts a stimulating action on the central nervous system.

In patients who develop drowsiness upon taking an antihistamine agent, the mild cerebral stimulation afforded by Hisdrin aids in overcoming this tendency and allows full mental and physical activity.

Hisdrin is indicated in the symptomatic control of all allergic states in which antihistamines are of value: seasonal hay fever, allergic dermatitis, drug reactions, and many types of pruritus.

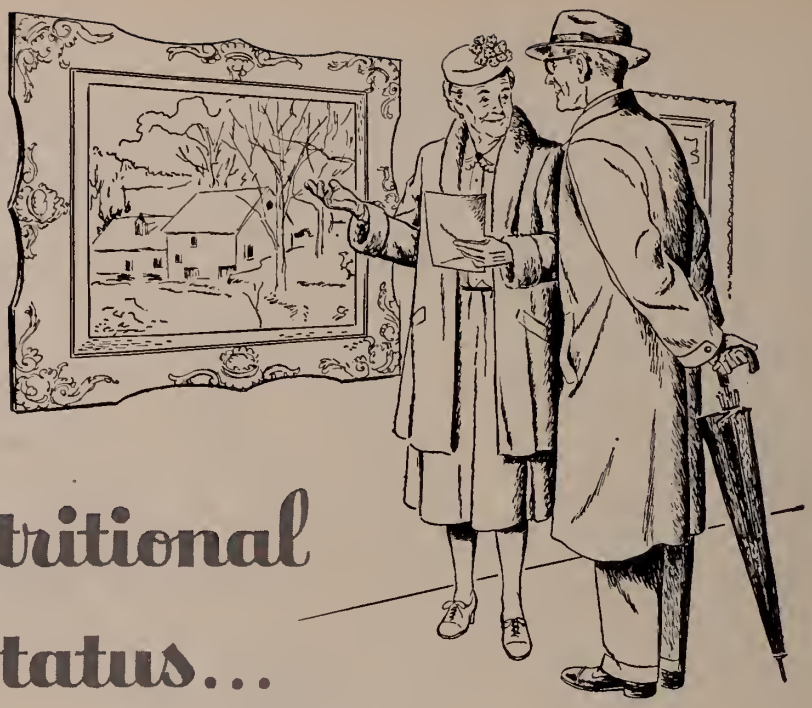
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Each Hisdrin tablet contains:
Semikon hydrochloride
(Methapyrilene hydrochloride) 50 mg.
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It is available on prescription
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AN IMPORTANT FACTOR IN OLD AGE

A RECENT study[1] of the health and nutritional status of 200 elderly patients and their dietary habits revealed their food intake to be deficient in iron, calcium, protein, and, particularly, B complex vitamins. In many instances the lassitude and premature weakness of the elderly are due to such deficiencies.

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Ovaltine in milk—a tasty, readily accepted and easily digested food supplement—offers a simple solution to this problem. Its wealth of biologically adequate protein, quickly utilizable carbohydrate, and needed vitamins and minerals, serves well in the aim of bringing nutrient intake to optimal levels.

The nutritional contribution of three servings of Ovaltine in milk (the recommended daily amount) is defined in the appended table.

1. Bortz, E. L.: Management of Elderly Patients, Postgraduate Med. 3:186 (Mar.) 1950.

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Ovaltine

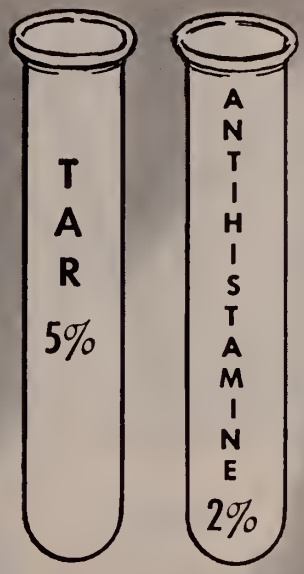
Three servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk, provide:*

PROTEIN	32 Gm.	VITAMIN A	3000 I.U.
FAT	32 Gm.	VITAMIN B_1	1.16 mg.
CARBOHYDRATE	65 Gm.	RIBOFLAVIN	2.0 mg.
CALCIUM	1.12 Gm.	NIACIN	6.8 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN C	30.0 mg.
IRON	12 mg.	VITAMIN D	417 I.U.
COPPER	0.5 mg.	CALORIES	676

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.





The first combination of tar and proven antihistaminic, pyrilamine maleate, in a clean, hydrophilic base, affording *not only pruritic relief*—but *treatment of the condition itself!*

HISTAR'S efficacy is evidenced in the results of recent clinical investigation of 52 dermatologic patients . . . 71% experienced marked improvement of the disorder — 75% experienced marked relief of accompanying pruritus!*

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*Walters, J. D. & Gilman, R. L.: A Combination of Tar and Antihistaminic For Local Use, *U. S. Armed Forces M. J. 2:187 (Feb.) 1951.*

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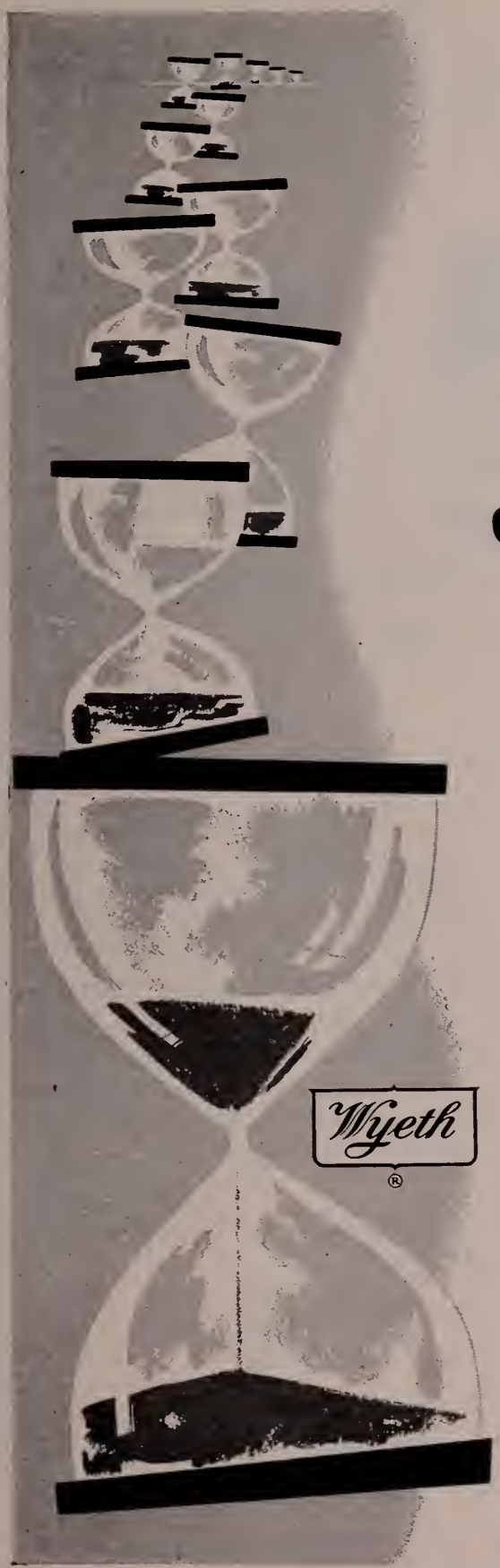
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Its antihistaminic action far outlasts PHENERGAN'S sedative effect—the only important side action (1 out of 5 cases), and a distinct advantage in the bedtime dosage regimen.

1. Bain, W. A., Broadbent, J. L., and Warin, R. P.: Lancet 2:47, 1949.

Issued in scored tablets of 12.5 mg., bottles of 100; on prescription only.

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HYDROCHLORIDE

N-(2'-dimethylamino-2'-methylethyl) phenothiazine hydrochloride

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When the diagnosis is Prostatitis

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consider **to establish and maintain urinary antisepsis...**

The value of MANDELAMINE* as a urinary antiseptic in the chemotherapy of prostatitis is based on (1) its wide antibacterial range, (2) exceptional freedom from drug-fastness —MANDELAMINE retains its therapeutic potency even against organisms which have become resistant to other antibacterial agents, (3) absence of untoward reactions in nearly all patients, and (4) simplicity of regimen.

Lowsley and Kirwin[1] recommend methenamine and mandelic acid in prostatic disease, especially when resistance or intolerance excludes the sulfonamides. A daily dose of 2.25 Gm. MANDELAMINE provides the antibacterial potency of 12 Gm. mandelic acid or 4 Gm. methenamine. Moreover, since MANDELAMINE approximates the sulfonamides and streptomycin in effectiveness, it may be used *first* whenever the diagnosis is prostatitis.

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MANDELAMINE is available in bottles of 120, 500, and 1,000 enteric-coated tablets through all prescription pharmacies. Literature and samples to physicians on request.

1. Lowsley, O. S., and Kirwin, T. J.: Clinical Urology. Baltimore, Williams & Wilkins Company, 1944; vol. 1, p. 939.

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It's *simply* physical

Diarrhea control does not require complex equations involving physical adsorptive powers for toxins and bacteria, physical coating potentials or hydrophilic capacity for physically concentrating stools.

Rx To achieve these goals quickly in diarrheal disturbances precipitated by dietary indiscretion, spoiled foods or intestinal allergies, the therapeutic equation simply calls for *physically effective*

Kaopectate*

Each fluid ounce contains:

Kaolin	30 grs
Pectin	2 grs

Available in bottles of 10 fluid ounces

Dosage: ADULTS — 2 or more tablespoons after each bowel movement, or as indicated

CHILDREN — 1 or more teaspoons according to age

*Trademark Reg. U.S. Pat. Off.

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for **EYES** *dissolving in the tears of* **DISTRESS**



ESTIVIN® will soothe the distressing ocular symptoms of hay fever.

ESTIVIN is a solution prepared from rose petals by a special process.

ESTIVIN has an anti-congestive and soothing effect upon irritated ocular and nasal membranes.

ESTIVIN, one drop, applied to each eye causes an almost instantaneous reduction of the congested Meibomian glands with complete relief from all irritation and discomfort.

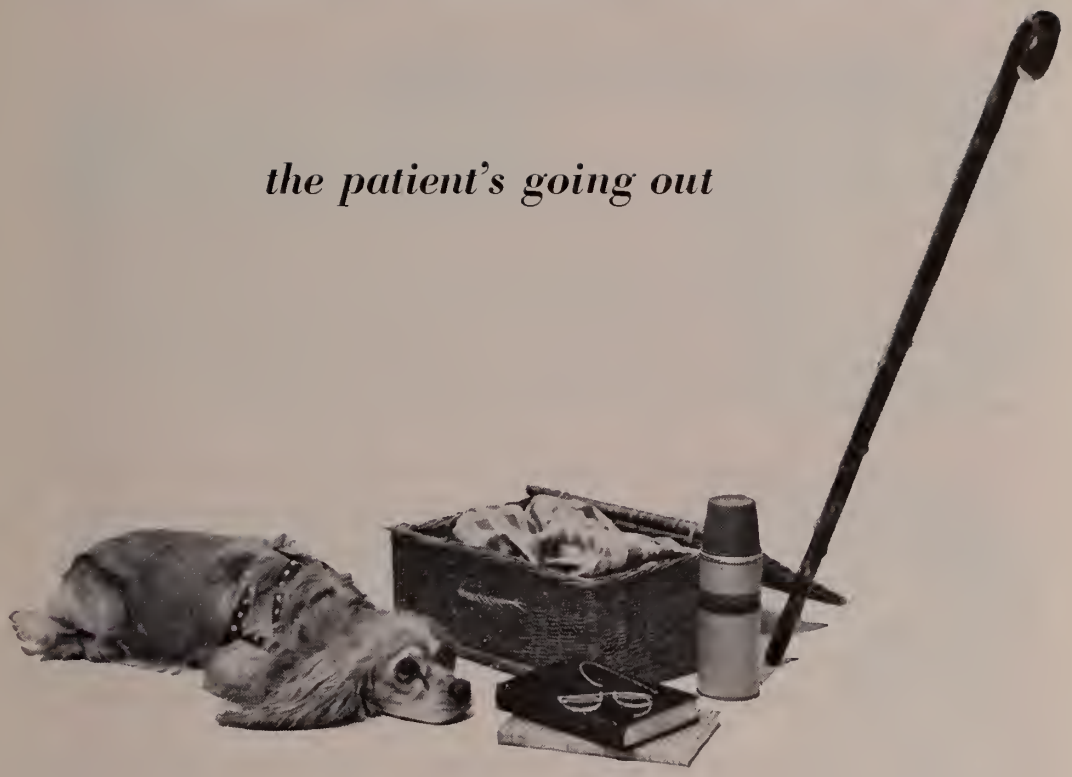
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the unique antidepressant and nutritive "tonic"

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MEAT in the Dietary Treatment of Ulcerative Colitis...

Of utmost importance in treating ulcerative colitis is the support of the nutritional state of the patient with a diet providing generous amounts of protein, vitamins, minerals and calories but giving a minimum of intestinal residue.[1, 2] Studies have shown that the most urgent nutritional need is for protein.[3] Other investigations have disclosed that patients with colitis display abnormally low serum levels for almost every vitamin.[4] Since most of these patients have anorexia, tempting food is essential for stimulating the appetite.

In particular, meat offers distinct advantages in maintaining the nutritional status and vigor of the colitis patient. Meat furnishes an abundance of protein, B complex vitamins and iron. Its protein contains all the indispensable amino acids in biologic proportions for growth and repair of tissues. Its B vitamins include thiamine, riboflavin, pyridoxine, niacin, and the recently discovered B_{12}. Being almost completely digestible, meat yields negligible intestinal residues which are non-irritating and non-stimulating to the intestinal musculature.

Another feature of meat in the diet of the patient with ulcerative colitis is its appetite-stimulating value for overcoming anorexia and promoting the digestive processes. In a widely used low-residue colitis diet,[2] providing from 60 to 80 Gm. of protein, 120 Gm. of meat and 10 Gm. of crisp bacon are included.

1. Mann, G. V., and Stare, F. J.: Nutritional Needs in Illness and Disease, J.A.M.A. *142*:409 (Feb. 11) 1950.

2. Barborka, C. J.: Treatment by Diet, ed. 5, Philadelphia, J. B. Lippincott Company, 1948, pp. 538-547.

3. Welsh, C. B.; Adams, M., and Wakefield, E. G.: Metabolic Studies on Chronic Ulcerative Colitis, J. Clin. Investigation *16*:161, 1937.

4. Bercovitz, Z., and Page, R. C.: Metabolic and Vitamin Studies in Chronic Ulcerative Colitis, Ann. Int. Med. *20*:239 and 254, 1944. Mackie, T. T.; Eddy, W. H., and Mills, M. A.: Vitamin Deficiencies in Gastro-Intestinal Disease, Ann. Int. Med. *14*:28, 1940.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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Logically Preferred—Clinically Proven!

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STRICTLY ETHICAL—ADVERTISED ONLY TO THE PROFESSION

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for ACUTE OTITIS MEDIA
REMOVAL OF IMPACTED CERUMEN
AS AN ADJUNCT TO SYSTEMIC ANTI-INFECTIVE THERAPY
CONTAGIOUS DISEASE EAR INVOLVEMENTS

FORMULA: Glyceral (DOHO) 17.90 GRAMS
(Highest obtainable spec. grav.)
Antipyrine 0.81 GRAMS
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for CHRONIC SUPPURATIVE OTITIS MEDIA
FURUNCULOSIS AND
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FORMULA: Urea 2.0 GRAMS
Sulfothiozole 1.6 GRAMS
Glyceral (DOHO) Base 16.4 GRAMS

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Nasal Decongestant *WITHOUT* Circulatory or Respiratory Effect

for COMMON COLD · SINUS INFECTIONS · PRE AND POSTOPERATIVE NASAL SHRINKAGE · HAY FEVER ALLERGIC AND HYPERTROPHIC RHINITIS

FORMULA: Desoxyephedrine Socchorinate 0.50% w/v in an isotonic oqueous solution with 0.02% Lourylommonium saccharin. Flavored. pH 6.4.

Supplied in **THE DOHONY SPRAY-O-MIZER*** (Combination Spray and Dropper)
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PLEASANT—EFFICIENT
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When Lactation Fails

Rx LACTOGEN®

When the supply of breast milk is inadequate or when lactation fails entirely, there is no better formula than Lactogen. Designed to resemble mother's milk, it consists of whole cow's milk modified with milk fat and milk sugar. It differs, however, in one important respect: the protein content of Lactogen in normal dilution is one-third greater than that of mother's milk—2.0% instead of 1.5%.

A Complete Infant Formula In One Package

Lactogen contains all the ingredients of a well-balanced infant formula. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk.

Easily Prepared . . . Merely Add Water

Lactogen is simple to use. The prescribed amount is stirred into warm, previously boiled water. Either a single feeding can be prepared, or the entire day's quantity can be made up and stored in the refrigerator until used.

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COLORADO SPRINGS, COLORADO

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NOTABLY HIGH IN PROTEIN CONTENT

Lactogen contains a generous amount of protein . . . more than enough to satisfy every protein need of the rapidly growing infant.



Two of these physicians suspected the worst...

but not until the significance and the incidence of amebiasis were thoroughly revealed at a hospital staff meeting. This meeting was held in a large city well north of the Mason-Dixon line, hardly a "tropical" climate, yet the incidence was high.*

The two staff men recognized that the symptom pattern of amebic dysentery fitted their experience of several months past and stool examination revealed that they, too, had amebiasis. A course of treatment for these physicians with Milibis-Aralen was completely successful.

Milibis — bismuth glycolylarsanilate — has given excellent results in thousands of cases. In 82.6% of patients followed parasitologically for prolonged periods, negative stools were obtained consistently after 1 to 4 courses of Milibis.

Because intestinal amebiasis may be complicated by extra-intestinal involvement, it is recommended that Aralen (chloroquine) diphosphate be employed in addition to Milibis for the treatment of all cases of amebic infection.

Illustrated booklet available on request.

HOW SUPPLIED:
Milibis, tablets of 0.5 Gm., bottles of 25;
Aralen, tablets of 0.25 Gm., bottles of 100.

***MILIBIS*®** *amebacide... high in potency... low in side effects*

***ARALEN*®** *...for extra-intestinal amebiasis*

Winthrop-Stearns INC 1450 BROADWAY, NEW YORK 18, N. Y.

5003M

*Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.

PHYSICAL MEDICINE ABSTRACTS



COMPRESSION FRACTURES OF THE SPINAL COLUMN

John C. Ivins, M.D., Rochester, Minn. In MINNESOTA MEDICINE, 33:2:154, February 1950.

Such fractures are slow in consolidating; the mistake is commonly made of removing the plaster too soon. In any event it seems safe to say that flexion movement must not be allowed earlier than four months after injury. In the case of the comminuted fractures, it may be necessary to continue plaster immobilization for six months or longer.

Throughout this period of immobilization in a plaster jacket, exercises for the spinal and abdominal muscles are practiced regularly. A good system is to teach the patient a regular schedule of doing these exercises so many minutes out of each hour; they cannot be overemphasized. These exercises maintain the tone of the spinal muscles, and if they are properly done the strength of the supporting musculature should be greater at the end of immobilization than it was prior to fracture. Futhermore, such exercises tend to preserve normal flexibility in the spinal column and help in maintaining the patient's confidence in his recovery.

When a sufficient period of immobilization has elapsed, and roentgenograms show satisfactory bony healing, the plaster jacket is discarded. If the exercises have been faithfully done, it should not be necessary, in the average case, to apply a convalescent brace, such as the Taylor brace. However, these fractures commonly occur in people who work hard with their backs, and in such instances an additional period of strengthening exercises may be necessary. For this purpose, regular gymnasium exercises are best; two or three months may be required for this phase of the treatment.

ALTERATIONS IN SERUM PROTEIN LEVELS IN ACUTE HUMAN POLIOMYELITIS: RATIONALE FOR THERAPY

Jack Sheldon Chudnoff, M.D., Los Angeles. In CALIFORNIA MEDICINE, 73:5:401, November 1950.

Serial determinations of serum protein levels in acute human poliomyelitis revealed a progressive drop of the serum albumin level which bore close relationship to the amount of clinical paralysis. This loss of serum albumin began about the third day after onset of clinical symptoms and progressed to the tenth day or longer. The more severe the clinical involvement, the loss was the tendency to spontaneous correction of the albumin deficiency. Declining serum albumin levels were concomitant with progressively rising serum globulin values.

When pooled irradiated human blood plasma

(*Continued on page* 60)



SIGMOIDOSCOPIC
VIEW OF RECTUM

in dysentery due to Shigella paradysenteriae:

"Six children between the ages of four and six years . . . given terramycin. The diarrhea which was pronounced in each case stopped within 48 hours in the case of four patients and within 72 hours in the other two . . . In all cases, the organism disappeared from the stool after treatment was started and did not reappear."[1]

Terramycin "is an effective agent in the chemotherapy of . . . chronic bacillary dysentery."[2]

1. Dowling, H. F., et al.: Ann. New York Acad. Sc. 53:433 (Sept. 15) 1950.

2. Sayer, R. J., et al.: Am. J. M. Sc. 221:256 (March) 1951.

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Physical Medicine (Continued)

was administered, the depleted serum albumin levels were stabilized or made to approach normal. depending upon the severity of clinical involvement. It is felt that the administration of blood plasma resulted in definite clinical benefit with regard to the severity, extent, and duration of paralysis.

THE EFFECTS OF VARIOUS PHYSICAL PROCEDURES ON THE CIRCULATION IN HUMAN LIMBS

Robert W. Wilkins, M.D., Meyer H. Halperin, M.D., and Julius Litter, M.D., Boston, Massachusetts. In ANNALS OF INTERNAL MEDICINE, 33:5:1232. November 1950.

During the past 10 years a series of physiologic studies has been carried out on the effects of various physical procedures upon the circulation in the limbs, in the hope of obtaining information of practical value in the physical therapy of peripheral vascular diseases. The purpose of the present paper is to review and summarize this work in order that clinical imlications may be more easily derived. The physical procedures that have been studied may be grouped under three main headings: (1) heat; (2) posture, and (3) pressure cuffs.

Some of the results described in this paper have a practical bearing on the therapy of peripheral vascular disease. For example, reflex sympathetic vasomotor activity may be as important as local vasodilating factors in determining blood flow in the limbs. Furthermore, release of sympathetic vasoconstriction, as from warming the body, can have little adverse effect, except possibly through some side loss of arterial pressure in the proximal parts of distally affected limbs. Indeed, the patchy areas of gangrene that may appear in ischemic feet after a lumbar sympathectomy may be due, at least in part, to this mechanism. On the other hand local vasodilating methods, which in normal limbs produce marked increases of blood flow, may in diseased limbs not only fail to produce significant hyperemia but cause local tissue damage. Thus, the local application of heat, except of the most moderate and rigidly controlled sort, is a dangerous procedure in ischemic limbs which burn very easily. Likewise, attempts to cause local "reactive hyperemia" in limbs already ischemic

(*Continued on page* 62)

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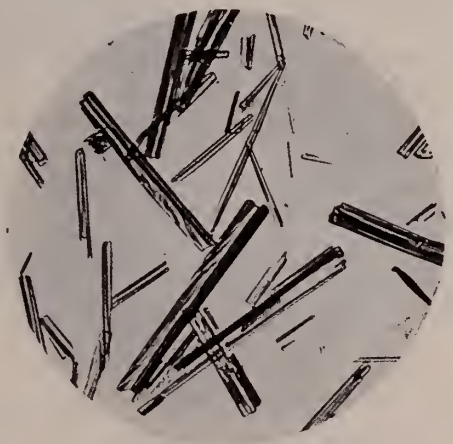
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appear not only futile but also hazardous, since extreme care is necessary in order to avoid traumatizing already devitalized tissues.

During Buerger's exercises a side loss of arterial pressure in the proximal vasodilated muscles may deprive the more distal and more needy parts of blood flow. Furthermore, muscular activity or tension in a limb greatly increases the utilization of and the need for oxygen. For these reasons it may be desirable in certain patients to use *passive* rather than active intermittent dependency. The definite increases in blood flow and oxygen tension found in the dependent limb would support such therapy. However, there seems to be no sound basis for elevation of the limb above the horizontal; on the contrary, a definite contraindication exists, since this procedure decreases blood flow.

No evidence was obtained in support of the rationale of intermittent venous congestion to relieve ischemia. In fact, all the data were in agreement that this procedure retards the blood flow. Admittedly, however, no observations were made bearing on the subsequent development of collateral circulation, a most important consideration in cases of peripheral vascular disease.

Apparently, local pressure of any degree reduces the blood flow in a part. Therefore, the pressure of dressings, casts, and even of the bedclothes on the limb, or of the limb upon the bed, should be avoided so far as possible. When linear accelerationn of venous flow is highly desirable—for example, in order to prevent phlebothrombosis—and when arterial inflow is adequate even with local mild pressurization, the use of elastic stockings or other types of local compression may be clinically useful.

It is hoped that these physiologic observations will be of benefit in the future physical therapy of peripheral ischemic vascular disease. At least they may help to emphasize that every case must be carefully evaluated, physiologic needs clearly defined, and therapeutic methods critically scrutinized before they are applied.



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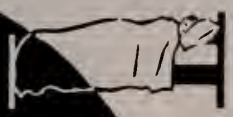
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1. Hoffman, Murray M., Ill. Dent. Jl., 19:439-445 (Oct., 1950)

2. McNealy, Raymond W., Ill. Med. Jl., 97:150 (Mar., 1950)

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All explosive weapons produce high blast pressure and release some thermal effect. An atomic bomb explosion is accompanied by the release of enormous quantities of kinetic energy, 80 per cent of which is in the form of heat. But the widespread fear of the people of the more mysterious gamma and neutron radiations has tended to obscure the importance of the thermal component of the bomb. Though the radioactive energy has fostered the greater fear among the peoples of the world, the great quantities of thermal and mechanical energy which are released produce the great physical damage, the large number of casualties, and the utter demoralization of the population subjected to the explosion. For instance, at Hiroshima the estimated deaths caused by ionizing radiation were approximately only 15 per cent of the total. It is true that many of the persons who were killed by blast and burns also had lethal doses of ionizing radiation. However, 85 per cent of the people who died at Hiroshima would have died if no ionizing radiation were present. Excerpt: Medical Aspects of Atomic Warfare, Richard L. Bohannon, M.D., New Orleans M. and S. J., June, 1951.

HOARSENESS

I cannot emphasize too strongly the importance of making a thorough examination in any case of hoarseness lasting over a week or two. I emphasize this because hoarseness is such a common symptom that unless it is accompanied by pain, or discomfort, it is frequently summarily dismissed by the patient, and by the doctor, as merely a trifling inconvenience. Unfortunately, in many serious conditions—many cases of malignancy for instance—there is no pain in the early stages, and it is only after the hoarseness has persisted for a considerable period that the patient is referred to the laryngologist for a thorough examination. There are other instances, of course, in which the patient alone is at fault. The condition is diagnosed early, but the patient delays too long in accepting the laryngologist's advice, and valuable time has been lost; especially in cancer of the larynx. Excerpt: The Significance of Hoarseness, Henry Boylan Orton, M.D., New Orleans M. and S. J., June, 1951.



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*Fry, C. O.: J. Am. M. Women's A. 4:51 (Feb.) 1949

BOOK REVIEWS



Essentials of Ophthalmology by Roland I. Pritkin, M.D., F.A.C.S., F.I.C.S., 215 Illustrations; including 18 subjects in colors. Philadelphia, J. B. Lippicott Company. $7.50.

This is a good eye book.

General practitioners and students will like the concise form in which a comprehensive view of the whole field of ophthalmology is presented. Oculists will see some appeal in the quick general review and the specific information relating to industrial ophthalmology, particularly the legal aspects.

The tables showing diseases of each of the eye structures will prove helpful. Especially so will be the table delineating ocular manifestations of general diseases and conditions.

Undoubtedly Doctor Pritikin will find a need for revisions in future editions. This reader would like to suggest as one change the use of drawings other than D, E, AND F of Figure 162. Those familiar with the technic shown will understand; others may believe the author makes the section and extraction of the cataract through the lower half of the cornea, mention of the superior rectus notwithstanding.

The personality and varied experiences of Doctor Pritikin as a soldier, physician, surgeon, teacher, lecturer and writer are reflected in this handy reference.

L. P. A. S.

Diseases of the Foot, by Emil D. W. Hauser, M.S., M.D., W. B. Saunders Company, 415 pages. 195 illustrations. $7.00.

This second edition has been printed in order to bring this fine edition up to date, including current use of antibiotics and other medications as well as improvements in treatment. The basic premise of the book is anatomy, and the normal findings, followed in order by the abnormal and their methods of treatment.

The chapter on circulation to the feet is particularly illuminating. The methods used in fracture dislocations and pathology in general is fundamental, concise and reasonable. It can certainly be said that spectacular and other methods of treatment which have not been given the test of time are not included. Certainly this book of 405 pages attains the summary of Dr. Hauser's years of experience in this field. It is to be very highly recommended to anyone interested in this field.

R. J. B.

Amputation Prosthetic Service, Earle H. Daniel, The Williams & Wilkins Company, 327 pages, 151 illustrations. $7.00.

This is a text written in non-technical terms which covers in full the problems of the amputee. The underlying philosophy of this book from the very beginning is that good stumps are made by good surgery. The Lisfranc, Chopart, Pirogoff and Syme's amputations are rather frowned upon and are suggested as being inferior to the below the knee amputation. The cineplastic method in upper extremity amputations is discussed. The psychological treatment of the amputee is also covered. The construction and mechanism of the artificial limb are gone into thoroughly. The entire history and personal status of the suction socket is explained in detail. Fitting and training are explained. The text is very fully and liberally supplied with x-rays and figures of many kinds.

Employment of the amputee and limb shop data, as well as a buyer's guide are included. The author believes that the amputee should be allowed to purchase any type of artificial limb which he thinks he would like to have. This abstractor does not agree with this premise, but believes that the attending surgeon should

(*Continued on page* 68)

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BOOK REVIEWS (Continued)

recommend the type of artificial limb which he knows will be best fitted and adapted to the amputee and the work which which he will ultimately follow.

R. J. B.

CURRENT THERAPY 1951 — Latest Approved Methods of Treatment for the Practicing Physician. Editor: Howard F. Conn, M.D., Consulting Editors: M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh J. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merritt, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis, Robert H. Williams. 699 pages. Philadelphia and London: W. B. Saunders Company, 1951. Price $10.00.

This latest edition of Current Therapy presents 49 new contributors. Eighty six of the methods are new and many others have been significantly changed.

The book has been compiled by a Board of 12 consultants and there are 275 contributors representing outstanding men in the various specialties.

This work is divided into 16 sections which cover all the major specialties. So thorough are the therapy techniques presented, that under each disease entity are offered, two and sometimes three different treatment methods.

The latest drugs have been included fairly so that when their ultimate values are still equivocal, it is so indicated.

J. W. P.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

PRINCIPLES AND PRACTICE OF OBSTETRICS (TENTH EDITION) Originally by Joseph B. DeLee, M.D. By J. P. Greenhill, M.D., Attending Obstetrician and Gynecologist, The Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, The Chicago Lying-In Hospital; Attending Gynecologist, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. New, 10th Edition. 1020 pages, with 1140 illustrations on 864 figures, 194 in color. Philadelphia and London: W. B. Saunders Company, 1951. Price $12.00.

ROENTGEN MANIFESTATIONS OF PANCREATIC DISEASE By Maxwell Herbert Poppel, M.D., F.A.C.R., Associate Professor of Clinical Radiology, New York University — Bellevue Medical Center, Associate

(*Continued on page 70*)

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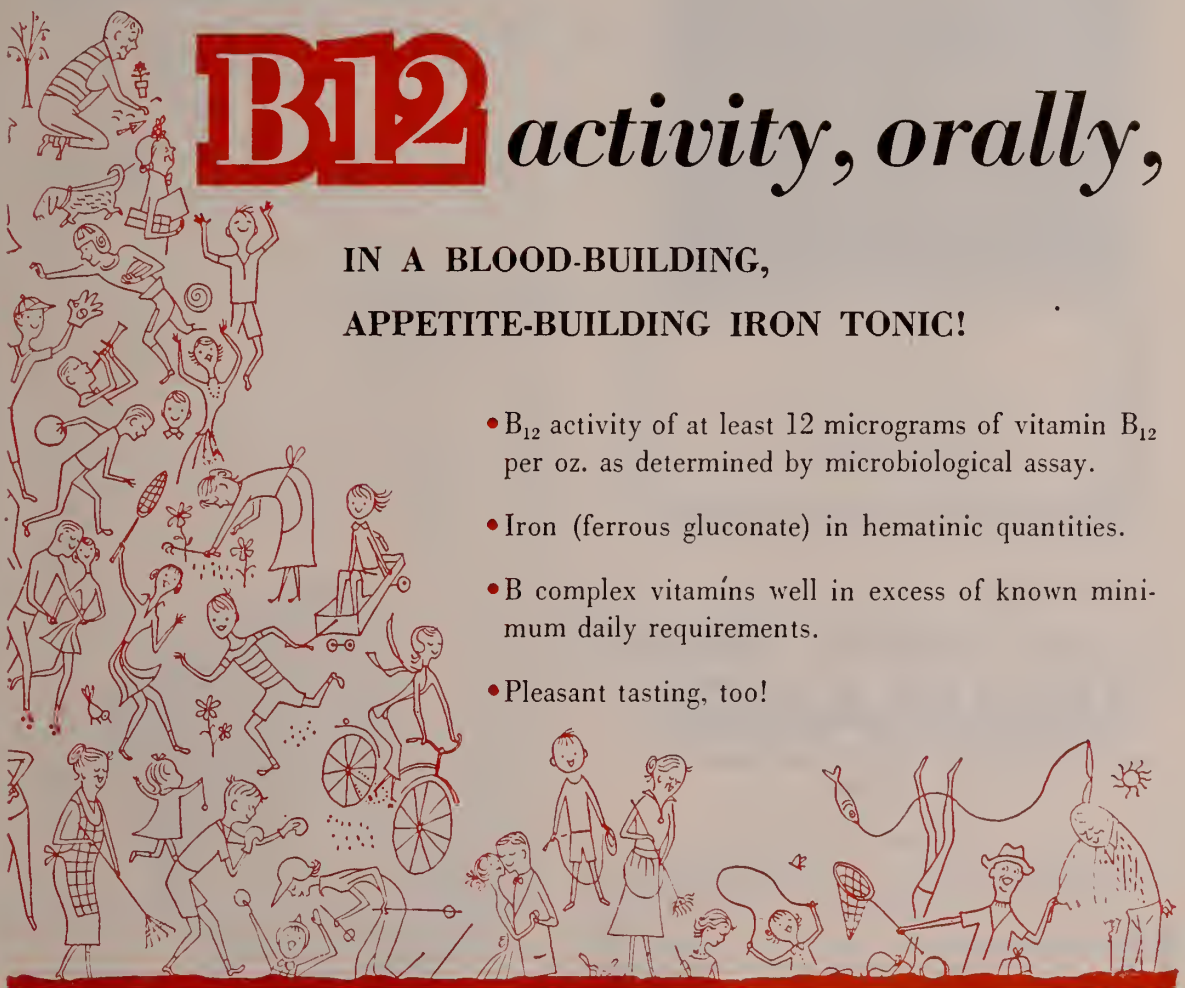
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BOOKS RECEIVED (Continued)

Roentgenologist, New York University Hospital, Associate Radiologist, Mount Sinai Hospital, Roentgenologist, Welfare Island Dispensary, New York City, Consultant in Radiology, United States Naval Hospital, St. Albans, Long Island, New York, Attending Consultant in Radiology, United States Veterans Administration Hospital, Bronx, New York Commander (Medical Corps), United States Naval Reserve. Charles C. Thomas, Publisher, Springfield, Illinois. $10.50.

TREATMENT OF THE NEPHROTIC SYNDROME. By Lee E. Farr, M. D., Chairman, Medical Department, Brookhaven National Laboratory, Physician-in-Chief, Brookhaven National Laboratory Hospital, Upton, Long Island, New York. Charles C. Thomas, Publisher, Springfield, Illinois. $1.75.

HANDBOOK OF NUTRITION — Second Edition. Prepared under the auspices of the Council on Foods and Nutrition of the American Medical Association. 7 charts; 28 tables; 35 figures; 717 pages; May 9, 1951. The Blakiston Company, New York, Toronto, Philadelphia. $4.50.

A HISTORY OF NEUROLOGICAL SURGERY. Contributors: William J. Atkinson, Kenneth M. Browne, John V. Crawford, Robert G. Fisher, Robert E. Green, Herbert C. Johnson, James W. Markham, Curtis Marshall, Desmond C. O'Connor, W. Eugene Stern, Alfredo F. Thomson, A. Earl Walker, Editorial Committee: Robert E. Green, Herbert C. Johnson, W. Eugene Stern. Edited by A. Earl Walker, M.D., Professor of Neurological Surgery, The Johns Hopkins University. The Williams & Wilkins Company, Baltimore, 1951. $12.00.

A REVIEW OF MEDICINE. By Members of the Faculty, Northwestern University Medical School. Edited by Benjamin Boslies, M.D., M.S., Ph.D., Associate Professor of Nervous and Mental Diseases, Northwestern University Medical School, Attending Neuropsychiatrist Passavant Memorial and St. Luke's Hospitals, Chicago, Illinois, and Senior Consultant in Neurology, Veterans Administration Hospital, Hines, Illinois. Sixth Edition; revised, appended and reset. Chicago, Illinois, 1951.

PHILOSOPHY FOR THE COMMON MAN. By Heinrich F. Wolf. Philosophical Library, New York. $3.50.

THE DIAGNOSIS AND TREATMENT OF ADRENAL INSURRICIENCY. By George W. Thorn, M.D., M.A., (Hon.), LL.D. (Hon.) Hersey Professor of the Theory and Practice of Physic, Harvard Medical School; and Physician-in-Chief, Peter Bent Brigham Hospital, Boston, Massachusetts. With the Collaboration of Peter H. Forsham, M.D., M.A. (Cantab.) Instructor in Medicine, Harvard Medical School and Junior Associate in Medicine, Peter Bent Brigham Hospital, Boston, Massachusetts, Kendall Emerson Jr., M.D., Assistant Professor, Harvard Medical School, and Senior Associate in Medicine, Peter Bent Brigham Hospital, Boston, Massachusetts. Charles C. Thomas Publisher, Springfield, Illinois, 1951. $5.50.

(*Continued on page* 86)

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Dr. Charles F. Pabst, retired chief dermatologist of the Greenpoint Hospital of Brooklyn, has been waging a one man campaign against the dangers of sunburn for more than thirty-five years. He directs his attention mainly to the person whose skin will redden, blister and burn — but never tan. These are the soft, fair-skinned blondes and redheads, especially those with blue eyes. He coined the term "Heliophobe" to designate these individuals. Dr. Pabst's concern was not in vain; we know now that this group suffers the most skin cancer and is most likely to develop severe burns from the sun.

He labeled the olive skinned brunettes who tan without blistering as "Heliophile". Most of Pabst's work was done before the advent of our modern suntan lotions and ointments. He prepared Tan Commandments in 1935 which are still good and worth passing on to patients who seek a suntan:

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2. Do not sleep on the beach in the direct rays of the sun.
3. Don't sit in the sun when the body is wet after bathing.
4. Don't go bareheaded in strong sunlight.
5. Don't read books or play cards in the direct rays of the sun.
6. Don't drink highballs or strong liquor while exposed to the summer sun; alcohol and sunlight do not mix.
7. Don't sprinkle perfume on the skin before exposure to the sun; a severe inflammation of the skin may result.
8. Don't recline in strong sunlight after strenuous exercise.
9. Don't forget that blondes and brunettes react differently to the sun's rays; blondes burn more easily.
10. If your skin will redden, blister and burn, but never tan, you are a "Heliophobe" and should not expose yourself, as every new exposure means a new burn.





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Of late Dr. J. A. Bargen has been enthusiastic about the use of Cellothyl, which comes in 0.5 Gm. tablets, for constipation. It is a methyl cellulose which swells up in the bowel and becomes like a jelly.

The difficulty with all such bulk producers is that they tend to work beautifully for anywhere from a week to months and then the colon somehow becomes accustomed to them so that it will then no longer respond to the stimulus. The day a man first eats three figs his stools may be too bulky and his bowels may move four times. After ten days of eating figs, he may eat two dozen and remain constipated, with small stools.

Curiously also, after the colon has become accustomed to one form of bulk it may respond strongly to another similar one. A man discovered that if he will eat each day a few canned figs and then after a week change to canned plums, he can go on indefinitely without any constipation and with a perfect bowel function.

Actually, one can hardly imagine a more convenient way of curing constipation than the eating of canned figs and canned plums. They

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are tasty and cheap and they serve as breakfast fruit. Some persons with a sensitive colon will fear to eat the figs because of the seeds, but actually the seeds are so small that they will do no harm.

It is interesting that some persons can get help from eating prunes while others cannot. Some few persons get a perfect bowel movement from taking each morning before breakfast a small glass of sauerkraut juice. With this they should take two or three glasses of water, so as to form a salt solution that will run quickly through the bowel without causing any discomfort.

Another simple method that works well for some people is to drink physiologic saline solution. Often this will go right through the digestive tract without producing any discomfort. The thing to do is to put a third of a teaspoonful of table salt into a glass of water. Three or four such glassfuls can be taken while the person is dressing.

Sometimes when a woman with a highly sensitive colon is desperate for relief, she will find

(*Continued on page 78*)

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*Wilson, L.: New York State J.Med. 50:1386 (June 1) 1950

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REPORT ON TUBERCULOSIS

The nation's death rate from tuberculosis dropped about 9 percent in 1949, to 26.2 per 100,000 population, according to Dr. W. Palmer Dearing, Acting Surgeon General of the Public Health Service, Federal Security Agency. During the first 11 months of 1950, a further decline of 15 percent occurred, and the rate for this period was 22.6 per 100,000 population, he said, explaining that these figures are provisional, as data for 1949 and 1950 were based on a 10 percent sample of death certificates obtained from each State and the District of Columbia. Dr. Dearing also pointed out that because the death rate for 1950 was based on figures for 11 months only, no aggregate decrease in the tuberculosis death rate since 1948 can be computed at this time.

The death rate in the United States for all forms of tuberculosis has shown a downward trend for almost half a century, except for a slight rise in 1917 and 1918, during the influenza epidemic of World War I.

Since 1900, the death rate for respiratory tuberculosis has decreased 86 percent, from 174.5 per 100,000 population to 24.5, while death rates from other forms of the disease have declined 91 percent, from 19.9 to 1.7 per 100,000 population.

When the conviction that tuberculosis is an exquisite infectious disease has become firmly established among physicians, the question of an adequate campaign against tuberculosis will certainly come under discussion and it will develop by itself. The Aetiology of Tuberculosis, Dr. Robert Koch, 1882. Translated by Berna Pinner and Max Pinner, published by NTA.

The treatment of pulmonary tuberculosis is not a skirmish, not a battle, not a siege, but a long-drawn-out war with activity on many fronts. When treatment is started it must be based on strategic plans to suit the patient for a duration of at least five years, and maybe for a long lifetime. The plan must be to stifle and eradicate the infection while preserving at a maximum the function of the diseased part. Extensions of the disease and complications in other parts of the lungs and other parts of the body must be dealt with quickly and as fully as possible. Calif. Med., John H. Skavlem, M.D., December, 1950.

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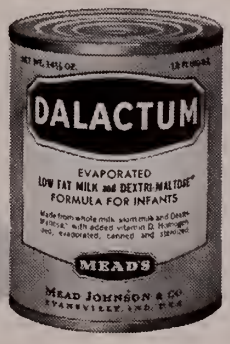
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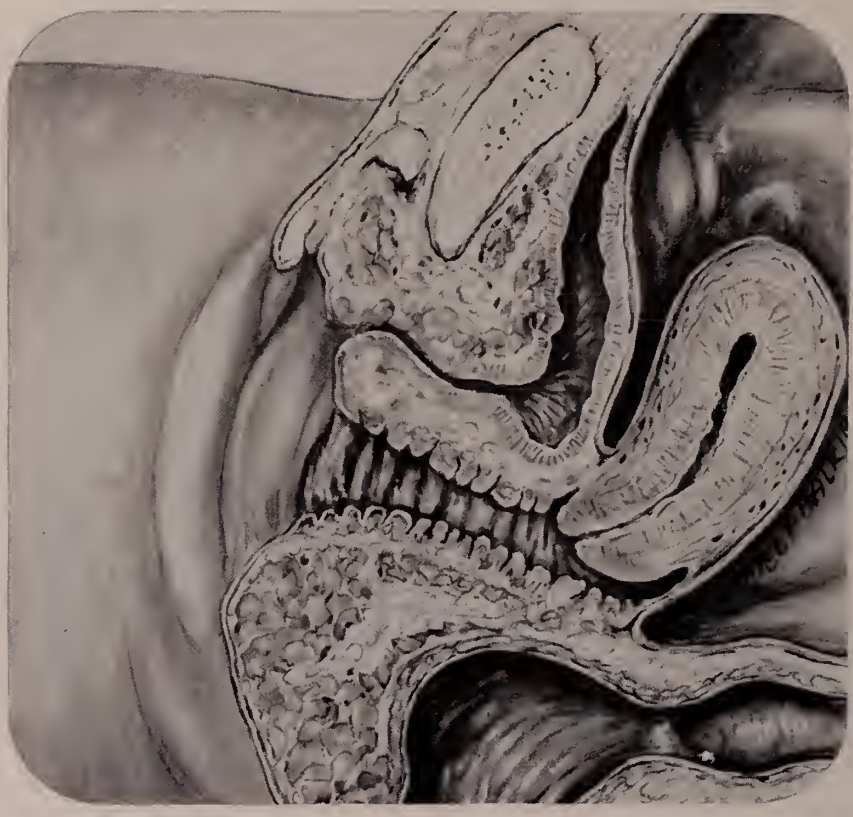
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Second Session of the House of Delegates

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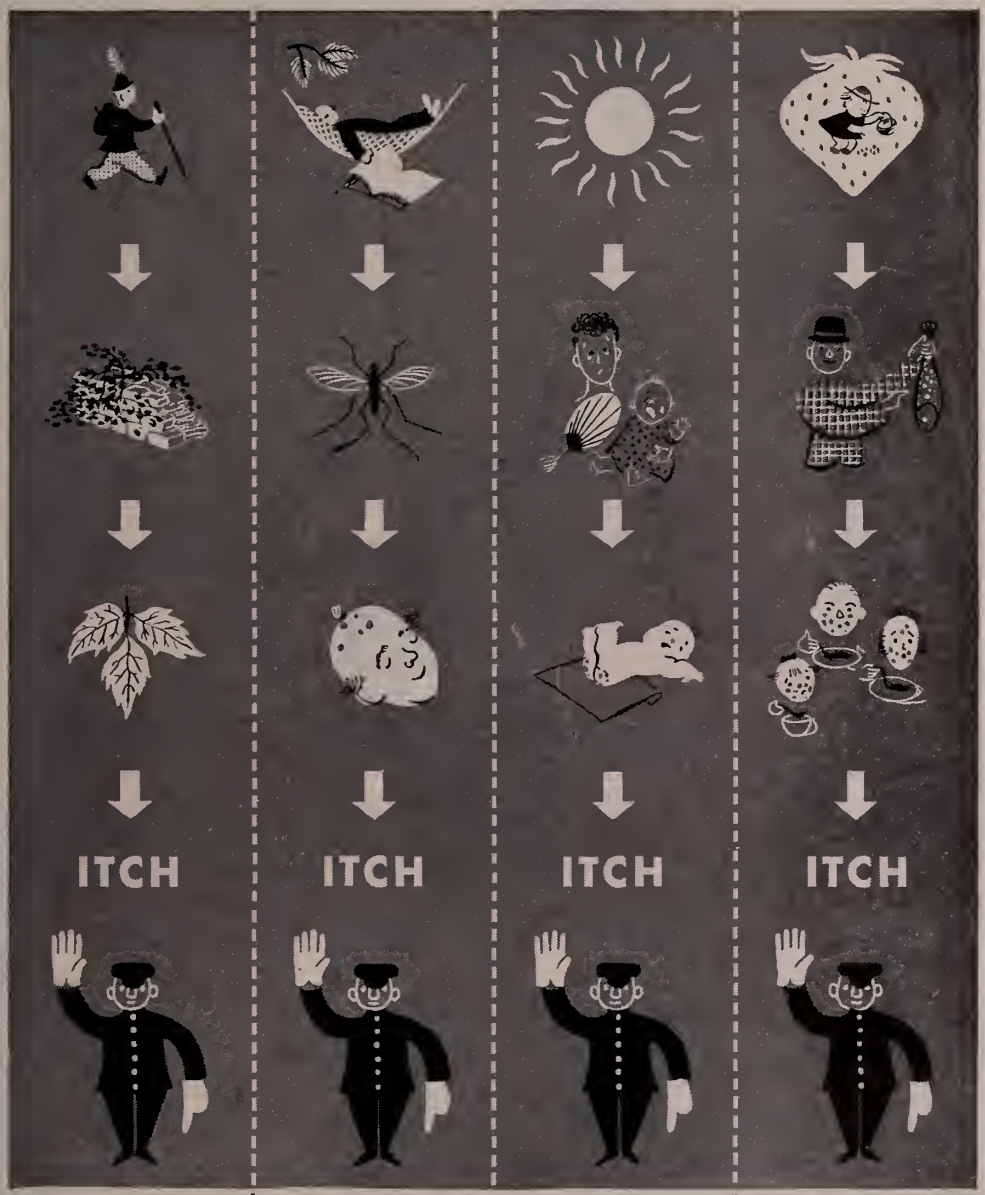
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*Passmore, G. G.: Treatment of Discharges from the Vagina in Private Practice, North Carolina M. J. 11:487 (Sept.) 1950.

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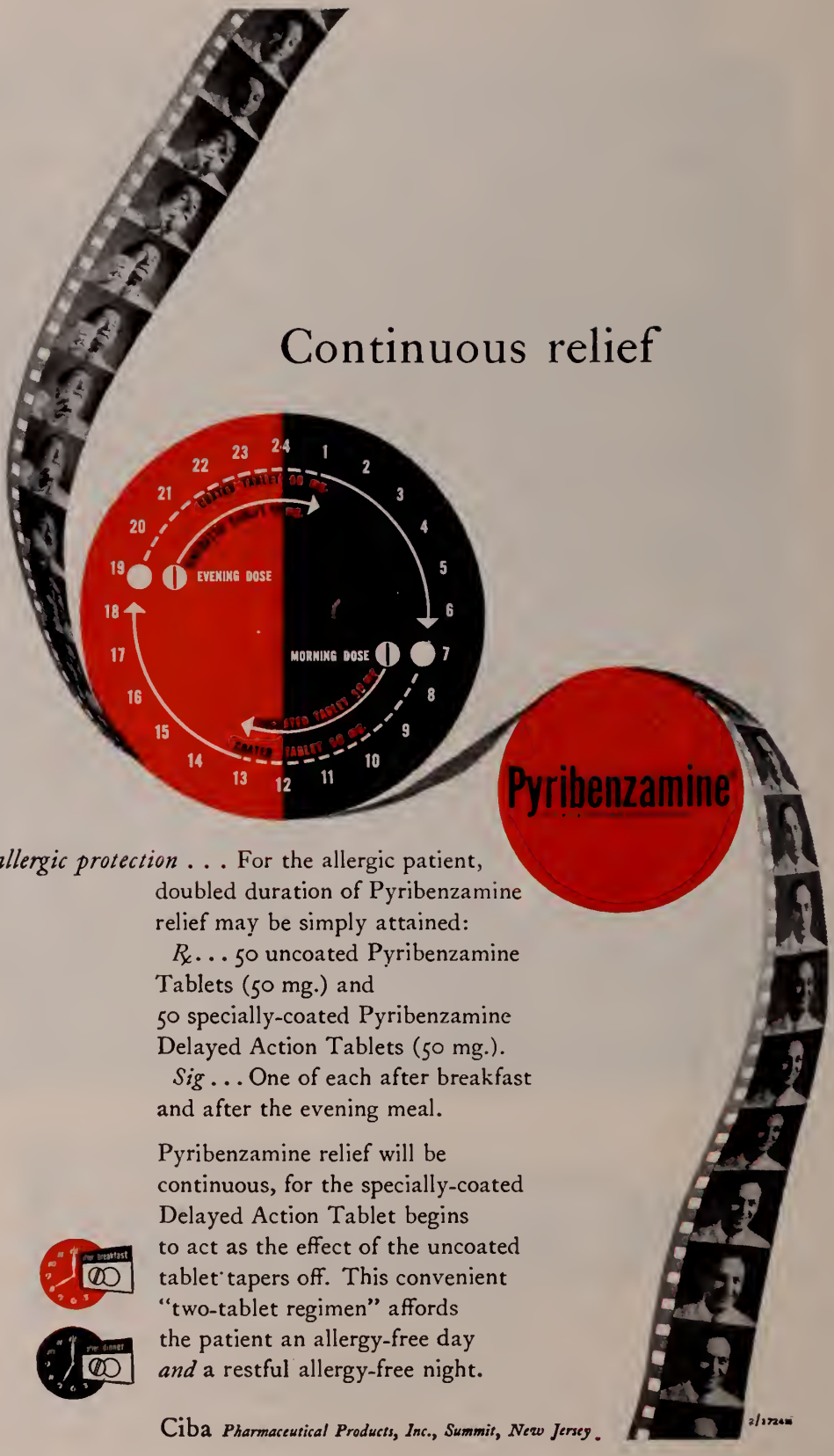


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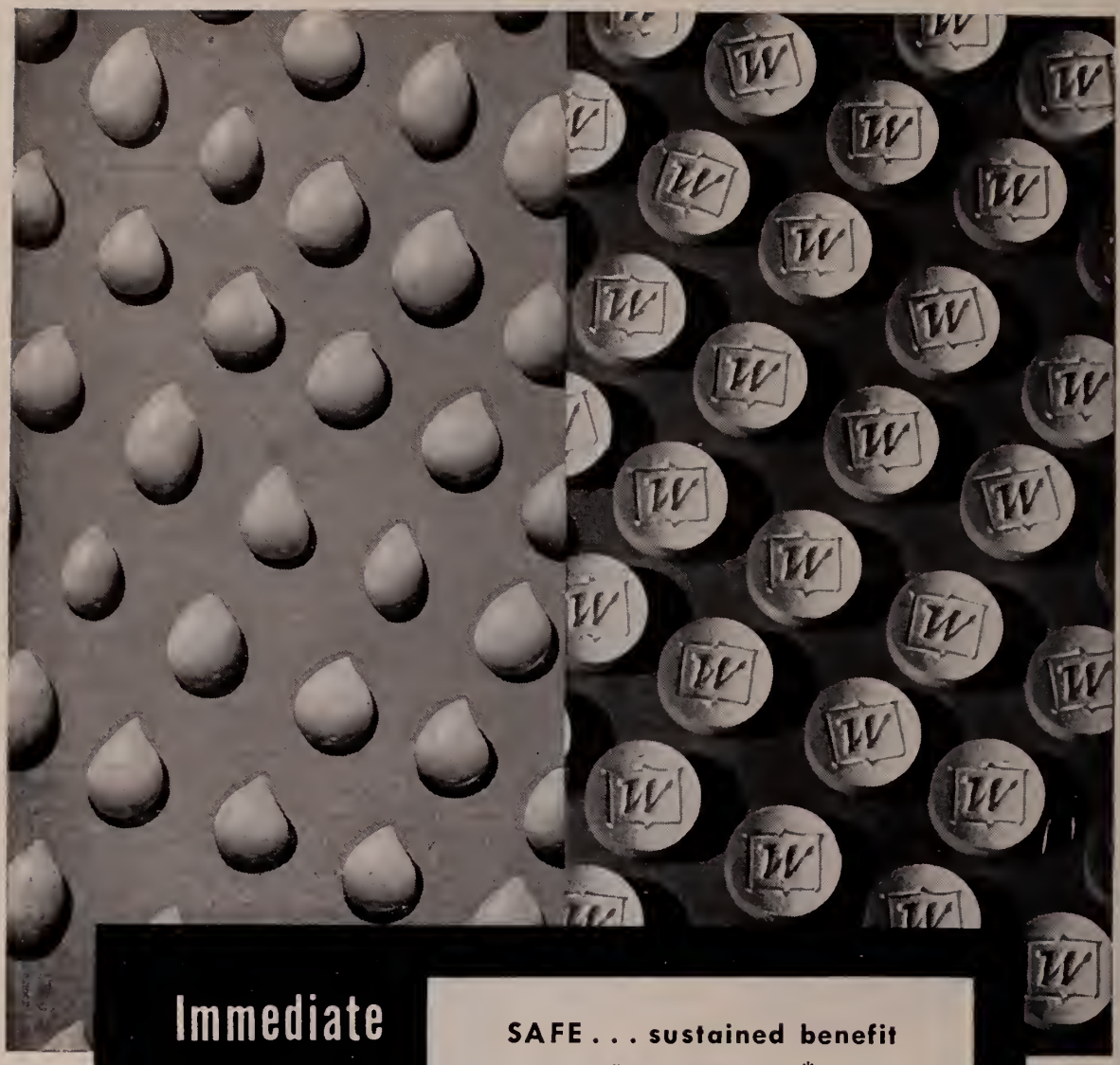
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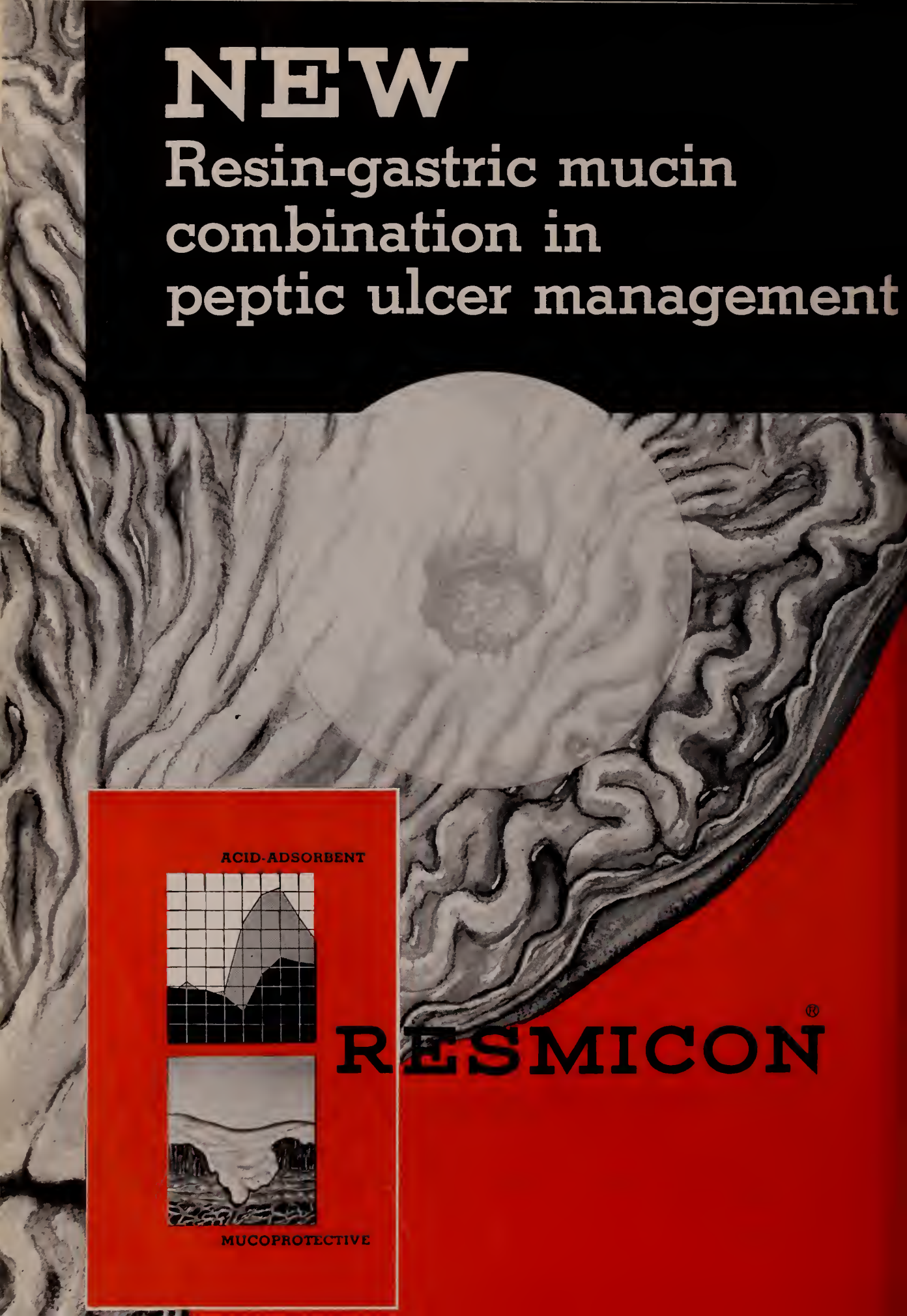
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*Steigmann, F., and Schlesinger, R. B.: A Resin-Gastric Mucin Mixture in the Medical Management of Peptic Ulcer, American J. Dig. Dis. *17*:361-365 (Nov.) 1950.

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A Dexamyl Case History

The unique value of Dexamyl* in providing symptomatic relief from mental and emotional distress is clearly demonstrated in this case history—from the file of a Philadelphia general practitioner.

Patient: B.H. (shown in photos on opposite page), age 46, married, the mother of a 16-year-old son. She has financial security and "no real cause for worry," but she "enlarges the simple vicissitudes of life until they become great anxieties."

The patient is mentally alert and has a fair sense of humor, but even this does not free her from her "moods" and apprehensiveness. "Her aches and pains are legion." She has frequent headaches attributable to the early menopausal syndrome. Most of her pain centers in the back along the spinal column. X-rays show osteoarthritic areas.

Her main complaint: morning depression and irritability.

Medical treatment: Dexamyl--2 tablets after breakfast and 1 tablet after lunch.

Results: "Dexamyl ... ironed out the morning so that the early hours were more tolerable. It soothed her anxieties; her son's boyish ineptitudes were made understandable; her household duties became less burdensome. Morning living became more livable."

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Each tablet contains 'Dexedrine' Sulfate, 5 mg.; amobarbital, Lilly, ½ gr. (32 mg.)

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Smith, Kline & French Laboratories, Philadelphia

These candid photographs of Patient B.H.—snapped unbeknown to her—were taken during an interview in her physician's office. This study of the patient describing her symptoms of mental and emotional distress forms an interesting complement to the case history on the opposite page.





All carried *Endamoeba histolytica*

...but only 1 out of 6 patients had no symptoms! Five of the 34 patients in this study[1] were classified as asymptomatic; 18 had such poorly defined symptoms that they would not normally seek medical aid...yet a stool examination proved that all had amebic dysentery.

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1. Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.
2. Berberian, D. A., Dennis, E. W., and Pipkin, C. A.: *Am. Jour. Trop. Med.*, 30:613, Sept., 1950.

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1. Stritzler, C.; Fishman, I. M., and Laurens, S.: *Transactions New York Acad. Sc., 13*:31, Nov., 1950.

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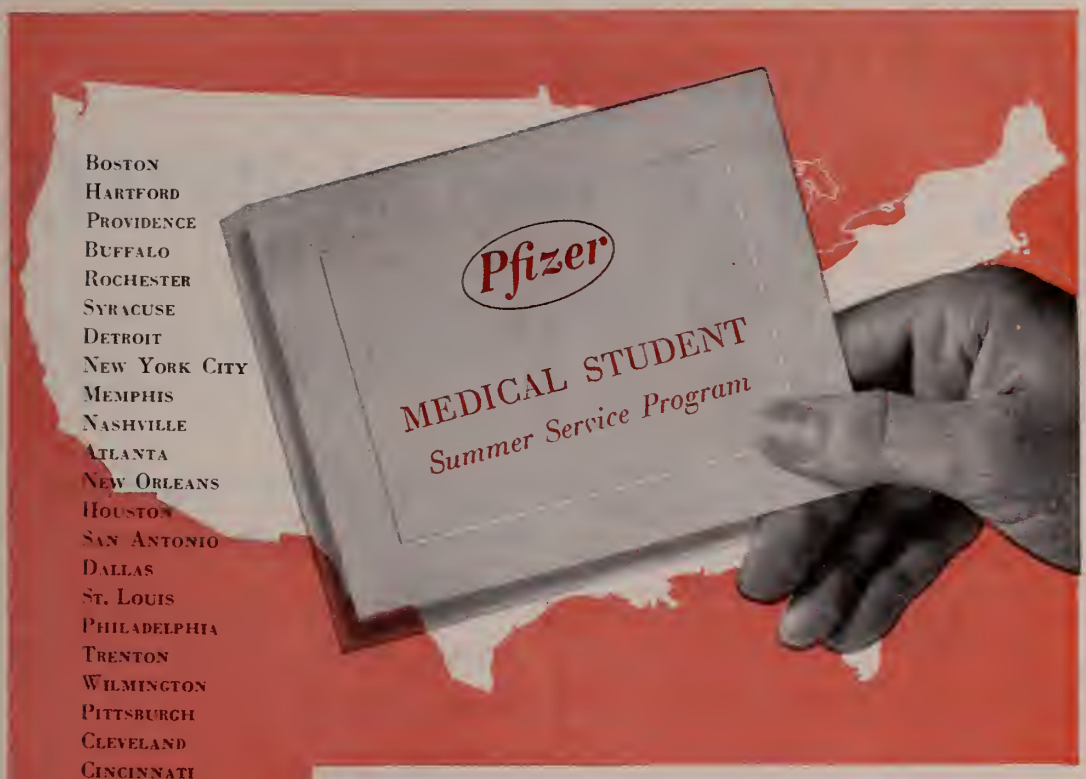


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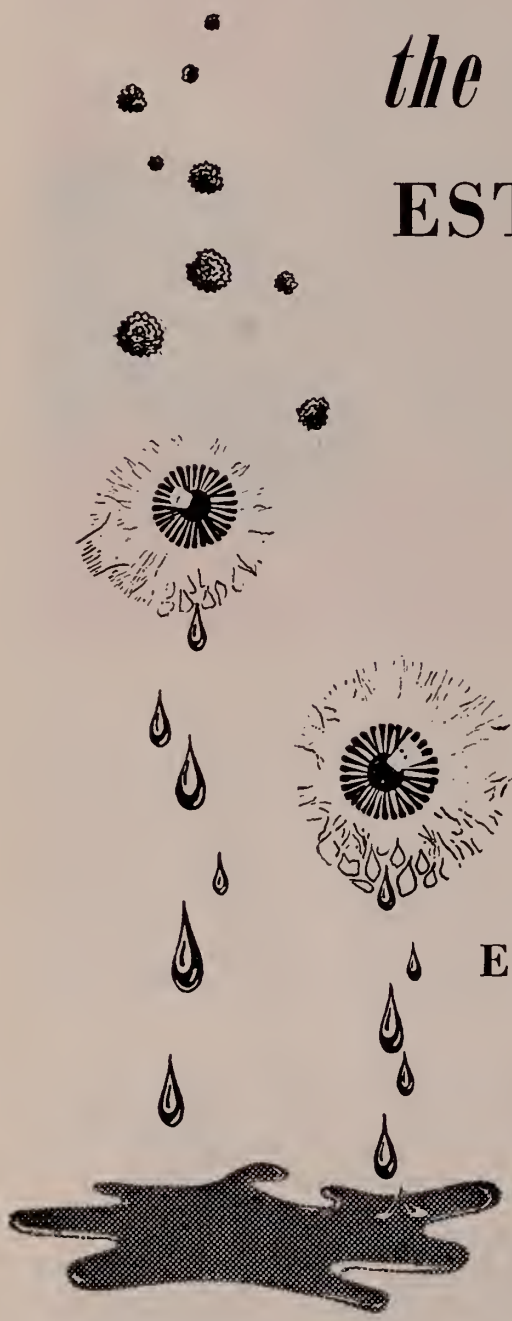
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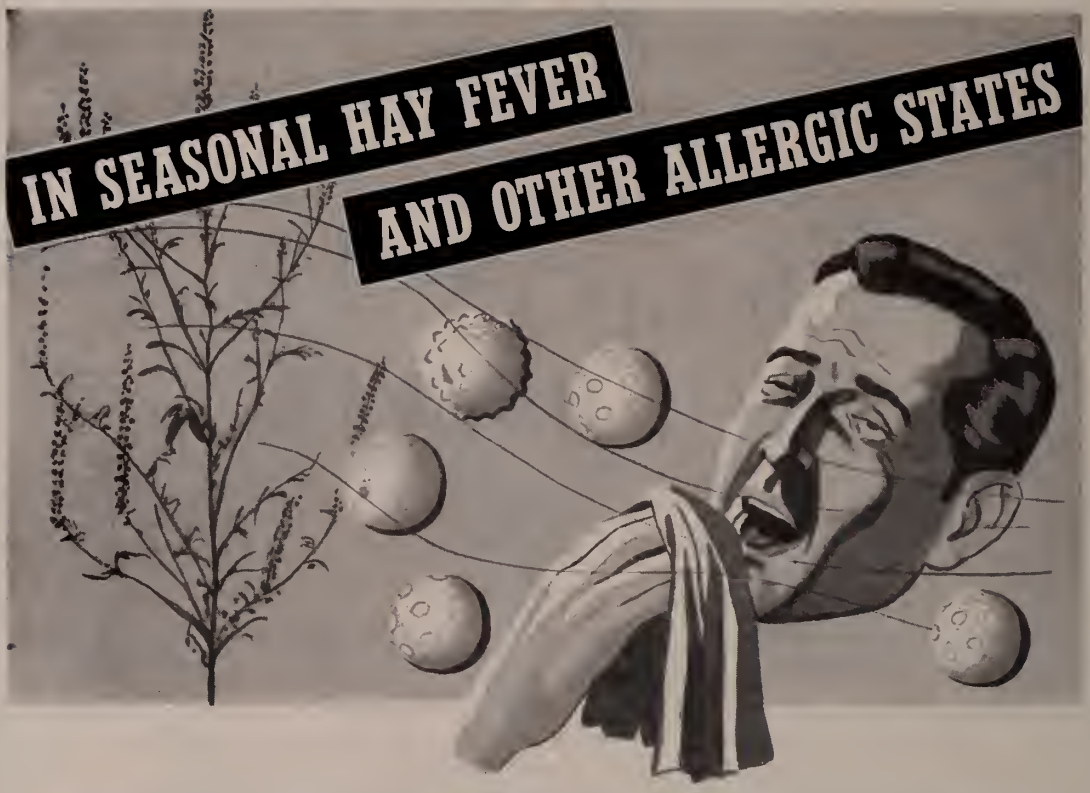


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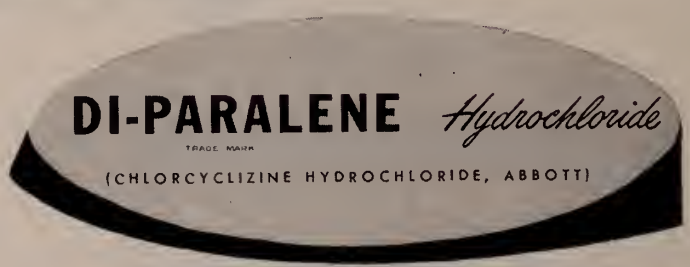
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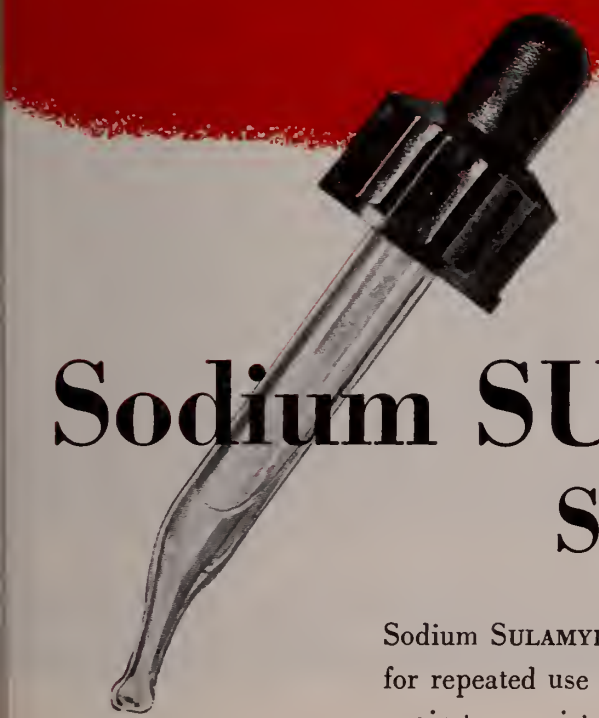
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REFERENCES: Spielman, A. D. (1950), N. Y. St. J. Med., 50:2297, Oct. 1. Brown, E. A., et al. (1950), Ann. Allergy, 8:32, Jan.-Feb. Jenkins, C. M. (1950), J. Nat. Med. Assn., 42:293, Sept. Cullick, Louis, and Ogden, H. D. (1950), South. Med. J., 43:632, July. Ehrlich, N. J., and Kaplan, M. A. (1950), Ann. Allergy, 8:682, Sept.-Oct.

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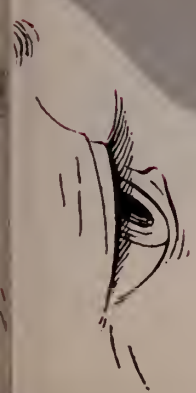
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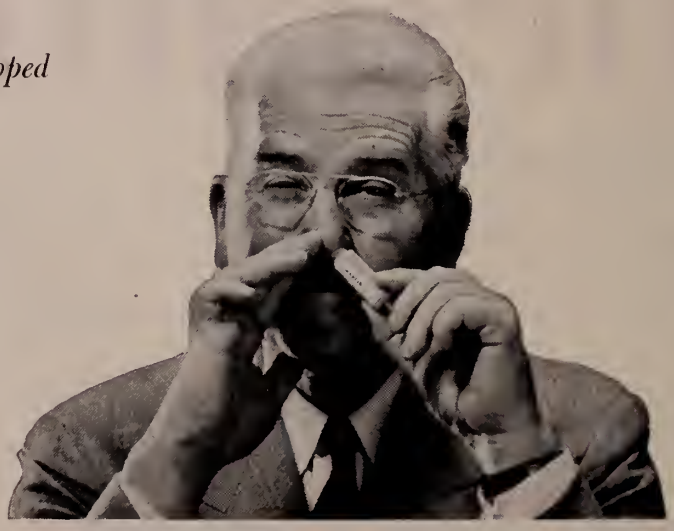
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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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Vol. 100, No. 2 August, 1951

FIRST ILLINOIS "CONFERENCE ON PHYSICIANS AND SCHOOLS"

A statewide Conference on Physicians and Schools will be held in Urbana, November 15 and 16, 1951 under the sponsorship of the Illinois State Medical Society in conjunction with the Illinois Dental Society, the Illinois Department of Public Health and the Illinois Department of Public Instruction. The conference will convene at 9 a.m., November 15 in the Illini Union Building on the campus of the University of Illinois. It will be similar to the one sponsored by the American Medical Association in Highland Park, Illinois, in 1947 and 1949 and the one to be held November 6-7-8.

The Superintendent of Public Instruction and the Director of the Illinois Department of Public Health, as well as the Chairman of the Illinois Association of Public School Administrators, the Illinois Public Health Nurses and School Nurses, and the Illinois Congress of Parents and Teachers are cooperating in the arrangements and promotion for this worthwhile conference.

Representatives of all agencies and individuals interested in schools and health of the school children of Illinois are being invited to attend. We believe it is of utmost importance that the leaders of all groups interested in the health of the school child take an active interest in the health services of his own community. It is in the interest of these individuals that this conference is being arranged, so that these community leaders and physicians will have a cooperative opportunity to devise methods to improve and extend School Health Services at the local level. We hope that this conference will stimulate joint action of all groups to develop sound school health services and that broad general principles can be outlined to assist each community in implementing its own school health program. We hope this conference will be a progressive step in promoting and providing a real health service to the school children of Illinois.

The conference will get underway Thursday, November 15, 1951, after registration at 9 a.m., with an opening assembly. At this assembly there will be brief discussions by the President of the Illinois State Medical Society, the President of the Illinois Dental Society, the Director of the Department of Public Health, the Superintendent of Public Instruction and the Consultant in Health and Fitness, Bureau of Health Education of the American Medical Association.

Those attending will divide into four groups, each with its own discussion leaders and consultants will work on some plan of school health services. Each group may explore its subject as deeply as time available for group meetings will permit, as well as being given an opportunity to rotate in to all of the panels. A general session Thursday night and a summary session

at luncheon on Friday will keep all registrants acquainted with the thinking of the other groups as well as provede stimulus.

The general conference theme will be "School Health Services". Subtopics will allow for discussion of today's problems in health appraisal, emergency care, referral and follow-up, health aspects of physical education, control of communicable diseases, accident prevention and many other subjects which may be suggested at the time. These topics will be considered in the light of good medical and educational practice and the professional relationships among educators, physicians in private practice, public health physicians and others concerned with school health problems. How these people can work together in the interests of school children will be emphasized.

ARTERIOSCLEROSIS

Arteriosclerosis is the "dumping grounds" for many complaints in individuals over 60. It is easy to blame the circulation for every headache, attack of dizziness, forgetfulness, irritability, insomnia or anxiety. How often do we search for other causes?

It is well recognized that arteriosclerosis begins after the age of 40 and is well established by the age of 60. But blood will flow through an arteriosclerotic vessel just as water runs through a rusty pipe. Finding evidence of arteriosclerosis, therefore, is not prima facie evidence that the condition is responsible for every indefinite symptom which develops after the age of 60. After all, an elderly man complaining of irritability or insomnia may be afraid that he will be fired from his job because he is old. There also is a possibility that he is worried about his grandson who is fighting in Korea. He may be lacking vitamin B, calcium or ascorbic acid. Those with fatigue, headache or dizziness may be taking barbiturates or bromides for insomnia and are sleeping too long or they may be working too hard, physically and mentally. Perhaps the symptom stems from mild diabetes, uremia, prostatic infection or hypothyroidism. In other words, "don't make a diagnosis of arteriosclerosis just because the patient is old."

There is evidence to show that this diagnosis is not always warranted. Oldsters with extensive mental changes, for example, often show no evidence of arteriosclerosis; those with severe arteriosclerotic changes as evidenced by the X-ray and retinal studies often have the keenest and most alert minds without the slightest trace of a mental change.

It is not a pleasant experience to walk away from the office of a physician with a diagnosis of arteriosclerosis and a bottle of phenobarbital tablets. To some it means the end of life's journey; for others degeneration has finally taken over. These individuals often admit that they have felt the effect of the aging process during the past decade but have done well in spite of it. After all, they have not missed a day of work and their decisions are being honored in business and industry. The man "with a little arteriosclerosis" is likely to go the doctor one better; he has been told what is wrong and now is anxious to do something about it. When we fail along this line they become dissatisfied. Let us not forget that this group constitutes a large proportion of our present-day population.

CIGARETTE SMOKING AND CANCER OF THE LUNG

Guest Editorial

"A custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs."—James I. of England on Smoking

For many years carcinoma of the stomach has been the commonest type of cancer in the male, causing 30 to 40 per cent of all cancer deaths and three times as many in the male as in the female. Now Graham* in his Ewing lecture, has gathered evidence that bronchiogenic cancer of the lung has displaced cancer of the stomach as the commonest cancer in men. This tumor has shown an enormous increase in incidence in the past thirty-five years and this augmentation has been progressively larger in the male than in the female. Statistical evidence is adduced to show that this is a real increase and not an apparent one due to the increased expectation of life. Certainly, as Graham notes, there was no lack of skilled pathologists in the nineteenth century able to recognize cancer of the lung for, even if special examinations of the bronchial tree were not always made at autopsy, the very consistency of the lungs makes it especially easy to detect in them abnormal masses of any kind. Experiences at the Barnes Hospital at St. Louis, where 1375

*Evarts A. Graham, Bull. N. Y. Acad. Med., 1951, 27, 261.

proven cases were recorded in the past forty years, are supported by figures from other large hospitals: the St. Louis City Hospital, the Charity Hospital at New Orleans and the Hines Veterans Hospital.

Two questions naturally arise: what is the cause of the tremendous increase in bronchiogenic lung cancer in recent years, and why is it that males are preponderantly affected? In general terms the possibility is suggested of some factor or factors associated with changes in our environment or habits or, the less likely possibility, that bronchiogenic cancer might be of infectious origin. This last hypothesis, suggested by the fact that the so-called "jagziekte" tumor of South African and Icelandic sheep, which is possibly though not proven to be of viral origin, closely resembles alveolar cancer of the lung, which however is not the bronchiogenic type, in human beings.

So far as our environment is concerned, the chief changes in the twentieth century have been increasing urbanization due to our vast industrialization, and the change in our methods of transportation, notably by motor car, with the accompanying development of the petroleum industry. These changes have led to a contamination of the air of our cities by exhaust gases from myriads of motor cars and other types of atmospheric contamination in the neighborhood of oil refineries, blast furnaces, and other industrial processes involving the combustion of fuels or the vaporization of various substances employed in our complex manufacturing projects. One must add that some dusty industries, such as the mining or utilization of substances rich in silica and the mining of pitchblende, are known to result in pathological changes in the air passages and, in the case of pitchblende, these may definitely take the form of lung cancer. However, figures show that men working in oil refineries and garages, where they are exposed to fumes, are no more subject to bronchiogenic cancer than other males, and it is also true that city dwellers show no greater incidence of this form of growth than the inhabitants of rural districts.

As to the preponderance of bronchiogenic cancer in males, the first question that arises is whether this sex-linked difference may be due to the action of sex hormones which, of course, are known to have an influence on the development of some malignant growths. Study of patients with bronchiogenic cancer furnishes no evidence that sex hormones play any role.

Graham suggests that there is another possible factor which has developed to enormous proportion in the past 50 years and that is the smoking of cigarettes. His studies indicate that the incidence of bronchiogenic cancer is much higher among male cigarette smokers than among female habitués, but he also points out that this is true only of men who have been heavy smokers over a long period of time, twenty years. He gives figures which show that, contrary to popular belief, excessive cigarette smoking in women is much less prevalent than in men and is mainly confined to a younger group. Consequently but few women smokers now alive can meet the requirement of excessive smoking over a twenty-year period. It is known that there are substances, such as tars, developed in the combustion of cigarettes, either from the tobacco or the paper, some of which may be carcinogenic. It may be added that cigarette smokers, as compared with pipe or cigar smokers, commonly inhale the smoke, thus presenting a greater opportunity for local irritation of the bronchial mucosa.

It should be emphasized that the increase in primary lung cancer occurs in the bronchiogenic type, usually designated as epidermoid or squamous-celled, and that a corresponding increase has not been observed in adenocarcinomata or the round cell type.

These observations were carefully made, much of the information about cigarette smoking was obtained by non-medical interviewers who were unaware of the purpose of the enquiry, the people interviewed were from all ranks of society and from all parts of the country, and every scientific precaution, such as adequate controls, was meticulously exercised. The evidence presented is certainly worthy of the most serious consideration, especially by cigarette smokers.

George Blumer, M.D.

The history of the field of tuberculosis, as a branch of medicine, has been an unfortunate one of isolation from the rest of medicine, engendered by geographic, climatic and even philosophic principles now clearly recognized as outmoded. It is time for the general physician and the lay worker to meet with the specialist in pulmonary diseases and in tuberculosis, for the more effective control of tuberculosis. Hoosier Health Herald, William B. Tucker, M.D., March, 1951.

CONGRATULATIONS TO ESTHER FRASER

At the meeting of the Medical Society Executives Conference held in Atlantic City during the recent meeting of the American Medical Association, Mrs. Esther A. Fraser, Assistant Secretary of the Chicago Medical Society, was elected Secretary-Treasurer for the coming year. She will serve in this capacity for the meeting scheduled to be held in Chicago during the A. M. A. meeting next June. This meeting of medical society executives is attended regularly by the representatives of state and county medical societies throughout the country, and has been increasing in popularity during the past four years.

The thousands of Illinois physicians who have known Mrs. Fraser who has been associated with the Chicago Medical Society for more than 35 years, offer their congratulations and best wishes. They are likewise very sure that she will aid materially in arranging the next Conference of this group to make the Chicago session a really outstanding affair.

IMMUNIZATION PROCEDURES AND PARALYTIC POLIOMYELITIS

"The possible relationship between paralytic poliomyelitis and injections for immunizing against whooping cough, diphtheria, tetanus, or injection of other biological and medicinal substances recently has been the subject of intensive study by English, Australian and American workers. The English and Australian workers have concerned themselves mainly with the effect of injection of substances for immunizing against diphtheria, whooping cough and tetanus. The American investigators, in addition, have studied the possible effects of injections of such other substances as penicillin, novocaine, etc.

"Cases of paralytic poliomyelitis were studied in respect to injections of the substances mentioned above prior to onset of the disease. When such an injection had been received within the month immediately preceding, the limbs in which the injections had been made were paralyzed more frequently than were the corresponding limbs of cases with no history of recent injections. No such relationship has been found in cases where such injections had been given more than a month before the onset of poliomyelitis.

"The studies do not show that injections for the prevention of whooping cough, diphtheria, tetanus, or injections of other medicinal substances, are the cause of poliomyelitis. The great majority of cases of poliomyelitis give no history of recent injections. There is no evidence that poliomyelitis infection is any more frequent among persons who receive such injections than among those who do not. The possibility that an injection may in some way tend to convert an otherwise non-paralytic into a paralytic infection should be considered although it lacks proof. If established, it would mean that an injection of any of the substances mentioned, at a time when poliomyelitis is abnormally prevalent in the community, may entail some small added risk to the person receiving it. There is no reason to believe that the added risk would extend beyond the month immediately following the injection, or that any added risk exists at all if injections are given at a time when poliomyelitis is not prevalent in the community.

"In addition to the studies on human beings, there have been two reports of experiments on animals. These suggest that the interval between an injection of the virus of poliomyelitis and onset of paralysis is shorter in those animals previously injected with certain immunizing substances.

"However, these animals experiments do not give any real basis for deciding on the safety of immunizing a child in a given situation. Physicians are well aware that many medical procedures involve calculated risk. The relative risks of giving or withholding an injection must be weighed in each individual case. Whether an injection of a medicinal substance is needed can be determined only by the physician dealing with a specific patient. He must determine in each case when injections are and are not warranted.

"Studies on the relationship of paralytic poliomyelitis to injections of medicinal substances have not been completed nor have the results been properly evaluated as yet. Results reported to date are tentative and should not be considered at this time as final evidence. They should be considered only in the light of a warning against indiscriminate injections during periods of poliomyelitis epidemics.—*The National Foundation for Infantile Paralysis*

THE A.M.A. MEETING AT ATLANTIC CITY

The Annual Meeting of the American Medical Association was held at Atlantic City June 11-15, 1951. More than 12,000 members registered, and of this number there were 464 from Illinois. Illinois physicians were quite prominent in the programs, exhibits and as discussants of many papers which were presented.

The technical and scientific exhibits were displayed in the large convention hall; there were 297 scientific exhibits and 350 technical exhibits, the largest number to be presented at any meeting of the A. M. A. Two gold medals were presented to Illinois physicians; in group 1, a gold medal went to Willis J. Potts, William L. Riker, and Robert DeBord, Children's Memorial Hospital, Chicago, for their exhibit on Surgery for Congenital Heart Disease. The gold medal in group 11 was awarded to Walter W. Williams, Springfield, Massachusetts, Irving F. Stein and Melvin R. Cohen, Michael Reese Hospital, Chicago, the exhibit on Fertility and Sterility — Diagnosis and Prognostic Procedure.

There were 37 medical motion pictures shown daily in projection rooms, and 17 color television demonstrations of surgical and medical procedures transmitted from the Atlantic City Hospital. These, as in recent years, were a most popular presentation. A total of 358 papers on many subjects in medicine were presented, as arranged by the Council on Scientific Assembly. Here too were a number of presentations by members of the Illinois State Medical Society.

The House of Delegates was very busy during the Annual Meeting, with the usual number of meetings, introduction of many resolutions, changes in Constitution and By-Laws, and many other important assignments. Reference Committees held long sessions at which literally hundreds of members of the Association appeared to present their views on the subjects under discussion. The ten elected delegates from the Illinois State Medical Society were all present at each session. In addition to these elected delegates, Illinois physicians seated in the House as Section Delegates, were Edward L. Compere, Section on Orthopedic Surgery; Percival Bailey, Section on Nervous and Mental Diseases, M. G. Westmoreland, Section on Pathology and Physiology, and Julius H. Hess, Section on Pediatrics.

The President and Secretary of the Student A. M. A. attended the meetings of the House of Delegates, as ex-officio members. One of these was an Illinois student — Harry Sandberg of Moline, from the University of Illinois College of Medicine.

Among the Illinois physicians who were prominent and active in the affairs of the American Medical Association are Edwin S. Hamilton, Kankakee, as Resident Trustee, and Josiah J. Moore, Chicago, Treasurer. Charles H. Phifer, Chicago, is a member of the Council on Scientific Assembly; Ernest E. Irons, Chicago, a member of the Council on Medical Service; Council on Pharmacy and Chemistry, Carl A. Dragstedt and Morris Fishbein, Chicago; Council on Physical Medicine and Rehabilitation, A. C. Ivy and Derrick Vail, Chicago; Council on Industrial Health, Harold A. Vonachen, Peoria. The late Ludvig Hektoen was a member of the Council on Scientific Exhibit. Paul H. Holinger, Chicago, served as a member of the Committee on Awards.

Several amendments to the Constitution and By-Laws were adopted, all of which appear in the printed transactions of the Meetings on the House of Delegates in the Journal of the A. M. A., and all members of the Illinois State Medical Society are urged to look them over carefully.

We will comment on only a few changes in the By-Laws which should be of interest to the members of this Society.

Division 1, Chapter 11, Section 2. ANNUAL DUES may be prescribed for the ensuing calendar year in an amount recommended by the Board of Trustees and approved by the House of Delegates. Each active member shall pay said annual dues to the constituent association for transmittal to the Secretary of the American Medical Association.

Dues will include subscription to the Journal of the American Medical Association.

The Board of Trustees may excuse a member from payment of dues for the following reasons, provided he is fully or partially excused from the payment of local dues by his component and constituent associations.

(A) Members on whom the payment of dues would work a financial hardship. This fact must

be certified by the secretary of the member's component (county) society;

(B) Members retired from active practice;

(C) Interns and residents during the first five years following graduation, except that the time spent in military services may be excluded in calculating the five year limit;

(D) A member temporarily in the Armed Forces. Dues will be remitted and prorated January 1 or July 1 following the date of the member's entrance into military service;

(E) Members over 70 years of age may be excused, on request, from the payment of American Medical Association dues, regardless of local dues exemptions.

May we suggest that all members of the Illinois State Medical Society spend some time checking over the printed transactions of the House of Delegates as presented in the Journal.

KREBIOZEN

Medical science has established procedures and standards of reporting progress of experimental and clinical results. The announcement in Chicago, March 26, 1951, of krebiozen, described as "an important step" toward a final goal of chemotherapy of cancer, ignored these procedures and standards. There was no publication in a medical or scientific journal; there was no presentation made before a learned society. Instead, krebiozen was announced to a mixed group of physicians, medical educators, public officials, and representatives of the press.

The information provided on this unusual occasion met few of the accepted criteria of medical reporting. One of the essentials when a new biological agent is presented is a clear account of the technic of its preparation or isolation and, when possible, an exact and complete description of its composition. No such information was provided as to krebiozen, except that it was separated from the serum of a horse after "stimulation" of its reticuloendothelial cells. Its method of preparation and its composition are expressly stated to be secret. The booklet distributed at this meeting, which purported to give clinical details on 22 cases, was gravely deficient for the purposes of evaluation.

Accepted requirements for medical reporting have developed because of the importance of protecting the profession and the public from false or misleading claims. Violation of these requirements, as the krebiozen incident demonstrates, has unfortunate consequences in arousing false hopes which tend to discredit the medical profession. Such a regrettable disregard for the established practice cannot be condoned. The conventions of reporting exist as safeguards against the well-intentioned motive as well as against that which is dishonest. The collective interests of medical practitioners and investigators of Chicago demand rigorous adherence to these conventions.—*Editorial from Vol. 18, No. 14, May 14, 1951 PROCEEDINGS OF THE INSTITUTE OF MEDICINE OF CHICAGO.*

93 YEARS OLD . . . AND STILL LEARNING

A convention old timer is Dr. E. B. Montgomery of Quincy, and he has his badges to prove it.

You're never too old to learn. especially when you're treating patients at the age of 93.

At 93, the principal medical interest of Dr. Edmund Brewer Montgomery of Quincy, Illinois, is geriatrics, but it is an interest that began more than 60 years ago.

Doctor Montgomery graduated from Jefferson Medical College, Philadelphia, in 1878, has been a practising physician since 1879 and has been a member of the Illinois State Medical Society and the American Medical Association since 1880.

He is the oldest member still in active practice who attended the Atlantic City session of the American Medical Association last month.

His interest in the problem of geriatrics (although they did not have that word for it then) began in 1890 when he was appointed surgeon to the Illinois Soldiers and Sailors Home at Quincy. He delivered a paper on his observations on the health problems of his 2,000 patients at a meeting of the Illinois State Medical Society in 1893. He said it made the now basic observation that the aged who have managed to survive intercurrent disease died of degenerative disease, but that degenerative diseases are not by any means confined to the aged and may be found in young persons as well.

Doctor Montgomery attributed his longevity to the fact that he was a delicate child whose medical professors predicted that he would not live much beyond the age of 25.

"That made me take good care of myself", he said. "I was careful of hygiene and I didn't



Dr. E. B. Montgomery, Quincy, displays some of the attendance badges he has collected over the years at medical meetings of the A.M.A.

Dr. Montgomery, at 93, was the oldest member still in active practice at the Atlantic City meeting. His interest is geriatrics.

drink or smoke, although I wanted to very much."

"My father was a heavy smoker, but he got a tobacco heart at 70 and only lived to be 93."

His current hobby, he said, is raising his year old grandson, but he also reads a wide variety of literature, especially Dickens. He spends several hours a day in his office and sees patients daily.

Dr. Montgomery was born in St. Louis, Missouri, May 11, 1858. His father was Robert Montgomery, a pharmacist who later became a wholesale druggist in Quincy. He first studied pharmacy, but soon shifted to medicine.

This material, together with the picture of Doctor Montgomery, were prepared by the Public Relations Department of the American Medical Association at Atlantic City. The picture and the above information were published in the Daily Bulletin printed for those in attendance at the meeting. Through the courtesy of the Public Relations Department of the AMA, the material has been made available for the Illinois Medical Journal.

Doctor Montgomery was introduced to the House of Delegates during the session, and was honor guest at the alumni session of the Jefferson Medical College of Philadelphia. Missouri claimed him by reason of his birth in St. Louis; Pennsylvania by reason of his education at Jefferson Medical College, and Illinois by reason of his long residence in Quincy, and his years of service to residents of this state.

Our congratulations to an outstanding physician for outstanding work over a long period of years. My we wish Doctor Montgomery success in his future activities an in his continued practice of medicine.

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Maloney, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



The Specialty of Anesthesiology

Max S. Sadove, M.D. and Henry C. Kretchmer, M.D.
(Guest Article)

With the re-absorption into the field of medicine of a clinical branch which formerly had been dominated by technicians, there has arisen a comparatively new medical specialty — that of anesthesiology. The anesthesiologist is today a practical pharmaco-physiologist, a consultant who is called upon to evaluate anesthetic risks and to suggest treatment and carry out procedures which will aid in minimizing that risk. He is specially trained in preoperative and postoperative care in inhalation therapy, resuscitation, shock therapy, transfusion and intravascular therapy and diagnostic and therapeutic blocks. The value of his services, which in the past usually have been requested only in the poor risk patient, are now being recognized to the point where routine cases receive the benefit of his knowledge and experience.

The field of anesthesiology presents many attractive aspects to the physician who is thinking of limiting his practice. As the specialty is a young one and still expanding, there is an unsatisfied demand for men with special training — a demand which is not likely to be supplied within the next 10 years, at least. The waiting period for an anesthesiologist to become established in a community is a relatively short one — much shorter than that in any other specialty. In most instances he can start earning a significant part of his expected income either immediately or within six months. To a great extent he can choose the method of practice which will suit him. For example, he can choose to work as an individual, or he can join one or more colleagues in several types of group practice. In hospitals which treat only charity patients or in teaching institutions, as well as in government services, there is a demand for qualified specialists who are reimbursed on salary basis.

If he practices alone, he can choose to divide his time between hospitals or concentrate his practice in one. If he joins a group, he must consider the advantages and disadvantages and decide whether he can adapt himself to such an arrangement. For example, will the personalities of the members of the group be compatible? Will he be accepted as an equal colleague or as a junior member of the group? If the latter, will

he be content with that status and income until his value to the group is enhanced and a readjustment in his standing made? In group practice he can reasonably expect to get adequate time either for vacations or to attend scientific meetings or both with little or no loss of practice or expected income. His services will be utilized somewhat more efficiently, with less time lost between cases.

If he is connected with a teaching or charity institutions, as a rule he cannot expect the income he would make in private practice. On the other hand, he will be able to stay abreast with the field, perhaps do original work of his own, and get the satisfaction of sending out men into the specialty who are well grounded in all the aspects of anesthesiology. As a rule, the hours are regular and the amount of time a man spends in daily practice once a routine is set up, is relatively predictable.

If a physician is going to limit his practice to anesthesiology, he must decide for himself whether he will desire certification. There is a real need in almost every community for men who have received adequate training in anesthesiology, regardless of their status as to certification.

If he wants to limit his practice to a minimum of 50% devoted to the specialty, he can seek certification by the American College of Anesthesiologists. Graduates of approved medical schools who have completed an accepted one year internship and present proof of actual training in an approved residency in anesthesiology for a minimum of one year, or proof that 50% of his actual practice has been limited to anesthesiology in AMA approved hospitals for a period of not less than five years immediately preceding the date of application, are eligible. Of course, the applicant must be a member in good standing of his county medical society or its equivalent, and an active member in good standing of the American Society of Anesthesiologists, Inc. The candidate is required to pass both written and oral examinations.

To obtain certification by the American Board of Anesthesiologists, the candidate must fulfill the same basic requirements as to society membership, i. e., medical school training and internship. The applicant's practice must be *entirely* limited to the specialty for a period of at least five calender years, of which at least two must have been in an approved residency in anesthesiology. He will be required to pass written, oral and practical examinations.

Excellent, approved residencies, which are competently organized to teach every phase of anesthesiology, both in the clinical and didactic phases, are available. These AMA approved residencies are under the supervision of certified anesthesiologists, some of whom are nationally and internationally recognized for their contributions to the field. The training is arranged in such a manner that a man receiving it is thoroughly prepared for his future work.

There is a growing awareness and demand by surgeons of the services of physicians who have received a special training in anesthesiology. It is the rare exception for a competent surgeon not to want the skill and experience of a trained anesthesiologist on the surgical team. Surgeons who have come in contact with the type of services which an anesthesiologist offers, continue to seek these services for their patient. The patient-physician relationship is one which should always be maintained in the specialty. A physician should not have to choose between a patient's best interest and that of the hospital. This is not always possible when one is an employee of a hospital. The fee-for-service plan holds the great hope and promise for the future.

The economics of the specialty are now in a state of flux. In view of the Hess report, and in view of the change from technician services to medical services, the usual financial arrangements between doctor and patient will result in most communities. In some communities, hospitals offer anesthesia as a service and hire anesthesiologists. However, there is a definite trend away from such arrangements. To quote the principles of medical ethics of the American Medical Association Chapter III Article VI Sec. 6 "Purveyal of Medical Service A Physician should not dispose of his professional attainments or services to any hospital, lay body or organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned . . ." Under the auspices of the American Society of Anesthesiologists a booklet based upon a survey of anesthesiologists

in the United States has been published which gives the average fees in various communities for the usual procedures by medical anesthetists in anesthesia. The reader may obtain a copy for a small fee by writing to the Society. The booklet will give him an idea as to his possible earnings in any given community.

In conclusion, it may be said that anesthesiology is a young expanding specialty with an unsatisfied demand for competently trained men. Just as obstretrics has graduated as a specialty from midwifery, as orthopedics has evolved from bone setting, as ophthalmology is differentiated from optometry, so now has anesthesiology become recognized as a medical specialty, differentiated from the administration of anesthesia by a technician. The ideal is to have every anesthetic administered by a physician who has had training in the field.

The present demand will not be fulfilled for many years. Economically, the men who enter the specialty can expect to do well. The smaller communities all over the country need trained men, and a physician who elects this specialty has a wide choice of locations. The advantages and disadvantages have been pointed out. The need for men who devote part-time as well as full-time to this specialty is great. With a background of adequate training, the opportunities for a successful practice are unlimited.

WEIGH CAREFULLY WORDS TO PATIENTS

We must never forget that everything we say to a patient is important to him. Likewise, our attitude is sensed by the patient. Therefore, we must try to be impersonal in our relationship and weigh our words carefully. Hope must never be taken away. For instance, if a patient has coronary artery disease with angina pectoris, I feel it wise to explain the condition to him, but I emphasize the point that mother nature is kind and causes a collateral circulation to develop which will allow him to live for years with his condition. So, when the patient does have organic disease, psychotherapy is again of the greatest importance, and with angina pectoris the patient should be helped to develop a philosophy of taking life and people less seriously in order to avoid emotional stress which may precipitate an attack of angina.

In other conditions, such as cancer or leukemia or Hodgkin's disease, it is of vital importance in my opinion never to tell the patient the true nature of his malady. One must then use his ingenuity to convince the patient that his disease is other than it is although it will take a long time to eradicate it. Dr. Will Mayo once told me that he was persuaded by a patient with cancer of his stomach to tell him what was wrong. "Dr. Mayo", he said, "I insist that you tell me the truth. I want to know, and I can live less unhappily knowing it than living in a state of uncertainty." So Dr. Mayo did tell him, whereupon the patient dropped dead. Such a salutary outcome would be rare. Most patients would be extremely unhappy since all hope of recovery would be denied them. Needless to say, Dr. Mayo never again allowed himself to be persuaded to tell a patient that he had such a dire condition. *Excerpt: Keeping Abreast of Medical Progress, Wallace M. Yater, M.D., Washington, D. C., Pa. M. J., May,* 1951.

CORRESPONDENCE



"YOUR MENTAL HOSPITALS" WHO SHALL LEAD THEM

The following is an editorial published in the June, 1951 issue of the American Psychiatric Association Mental Hospital Service Bulletin, written by the undersigned. It emphasizes the lack of positive action by a large segment of the medical profession toward an illness that fills not only half of the hospital beds of this State but half of the hospital beds of the Nation. An active Mental Health Section should be established in each County Medical Society to work with the State Medical Society, Mental Health Committee, the local physicians and the adjacent State hospitals. They are Your Mental Hospitals.

"One reads in the daily press, and in the weekly and monthly magazines, and in professional journals, articles on the advances and improvements in the care and treatment of mental patients and of the activities of state mental hospitals. One also reads of the many problems associated with these state institutions. Overcrowding of the hospitals, varying in degree, is almost NATIONAL. Shortages of funds and critical shortages of professional and nonprofessional personnel is the rule, rather than the exception. The need of expansion of clinics and a marked acceleration of research programs is well recognized.

"Over and above these serious and more tangible problems of the state mental hospitals is one that is as important (and possibly more important) for, if solved, it may be a means toward the solution of other problems. It is the apathy of the medical profession toward the state mental hospitals and their problems. This apathy even extends to fellow psychiatrists many of whom, though now engaged in private practice, received a considerable portion of their basic training in a state mental hospital. Shall the medical profession lead the way in alleviating the condition of the mental institutions, or shall it be left to a lay group? Shall the medical profession, general practitioners as well as psychiatrists, take an active part as they have done in other diseases and help solve the problems associated with the illness that fills over one-half the hospital beds of the United States?

"In recent years, the American Psychiatric Association has devoted more and more of its energy to mental hospitals. It has developed the Mental Hospital Service, which is an excellent means of exchanging knowledge between people engaged in mental hospital work. The Third Annual Mental Hospital Institute this fall will, again, present discussions planned to assist in the problems and daily programs of the hospitals.

"Members of the medical profession should strive to stimulate their fellow physicians and arouse their interest. The mental hospital belongs to all doctors, regardless of their daily activities. As medical men they should have an

interest in all illnesses whether they be physical or mental. Just as important is the need to arouse the interest of the psychiatrist who is not associated with a state mental hospital. He should be made aware of the problems and take an active part in their solution. He may be willing to devote some time to the institution by assisting in the treatment of patients, in research work, in training students, residents, and younger physicians, and in developing a liaison between the state hospitals and the medical schools. There is no greater field available for research or teaching.

"The repeated attempts to establish socialized medicine emphasizes the need for medical guidance in this branch of medicine that involves a half million hospitalized patients."

G. A. Wiltrakis, M.D.
Deputy Director

(NOTE: The Illinois State Hospitals need full and part-time psychiatrists as well as full and part-time physicians in all branches of medicine, including medicine, surgery, tuberculosis and public health.)

PHYSICIANS WANTED

The Veterans Administration Hospital, Downey, Illinois presently has vacancies for several physicians in the 217 bed Tuberculosis Unit of the hospital, as well as for an Internist in the General Medical Unit, Dr. Byron S. Cane, manager, announced recently.

Salaries for the positions are determined by the experience and qualifications possessed by the applicant. The salary range for physicians in the Department of Medicine and Surgery includes: Junior Grade, $5000 per year; Associate Grade, $5400 per year; Full Grade, $6400 per year; Intermediate Grade, $7600 per year; Senior Grade, $8800 per year; and Chief Grade, $10,000 per year. An additional 25% allowance of the base salary is given to those having a rating as specialist by an American Specialist Board. Determination of the appropriate grade for applicants will be made by thorough evaluation of qualifications by a Professional Standards Board. Promotions are available after meeting length of service and other requirements of the Veterans Administration.

In addition to the benefits mentioned above, physicians are granted 30 days vacation and 15 days sick leave each year.

Applicants must be between the ages of 21 and 54, hold a degree of doctor of medicine from an approved college or university, and have completed an approved internship, as well as possess a license to practice medicine in a state or territory of the U. S., and be able to meet satisfactory physical qualification standards.

Applicants should write to: Personnel Officer, Veterans Administration Hospital, Downey, Illinois, Phone: Waukegan, Illinois — Ontario 1900, Extension 422. The hospital is located 35 miles north of Chicago, and 5 miles south of Waukegan, Illinois.

CLINICS FOR CRIPPLED CHILDREN FOR SEPTEMBER

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois Division of Services for Crippled Children. The Division will conduct 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The September clinics are:

September 5 — Rosiclare, Y.M.C.A.
September 6 — Sterling, Sterling Public Hospital
September 6 — Clinton, Christian Church
September 11 — Peoria, St. Francis Hospital
September 11 — E. St. Louis, St. Mary's Hospital
September 11 — Quincy, Blessing Hospital
September 12 — Hinsdale, Hinsdale Sanitarium
September 12 — Alton, Alton Memorial Hospital
September 13 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

September 13 — Springfield, St. John's Hospital
September 14 — Chicago Heights (Rheumatic Fever), St. James Hospital
September 18 — Centralia, Franklin School
September 19 — Evergreen Park, Little Company of Mary
September 20 — Rockford, St. Anthony's Hospital
September 20 — Watseka, American Legion Home
September 25 — Peoria, St. Francis Hospital
September 25 — Effingham (Rheumatic Fever), Douglas Township Bldg.
September 25 — E. St. Louis, Christian Welfare
September 26 — Springfield (Cerebral Palsy), Memorial Hospital
September 27 — Bloomington, St. Joseph's Hospital
September 27 — Chester, St. John's Lutheran School
September 28 — Chicago Heights (Rheumatic Fever), St. James Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

In all cases, the work of the Division is intended to extend and supplement—not supplant—activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

INTERNATIONAL COLLEGE OF SURGEONS

The sixteenth annual assembly of the United States Chapter of the International College of Surgeons will be held in Chicago on September 10th through the 13th, 1951, with headquarters at the Palmer House.

An excellent program has been arranged. Prominent surgeons from the United States and other countries will participate. Scientific sessions will be held by all specialty sections of the United States Chapter.

The annual banquet will take place on Wednesday Evening, September 12. Mr. Lawrence Abel, F. R. C. S. (Eng.), of London, will be the principal speaker.

The assembly will conclude with the convocation, to be held in the Civic Opera House on the evening of September 13. Senator Estes Kefauver will deliver an address on "The America of Tomorrow".

Hotel reservations may be arranged by writing to the Housing Division, Chicago Convention Bureau, 33 North LaSalle Street, Chicago 2, Illinois.

GYNECOLOGICAL SOCIETY ELECTS OFFICERS

At the Annual Meeting of the Chicago Gynecological Society held June 15, 1951, the following officers were elected:

President, M. Edward Davis; President-Elect, Edward M. Dorr; Vice-President, A. F. Lash; Secretary, Edwin J. De Costa; Treasurer, Harry Boysen; Pathologist, Clyde J. Geiger; Editor, Janet Towne.

The Secretary's address is 104 S. Michigan Avenue, Chicago 3.

MISSISSIPPI VALLEY MEDICAL SOCIETY MEETING, PEORIA, SEPT. 19, 20, 21

The 16th Annual Meeting of the Mississippi Valley Medical Society will be held at the Pere Marquette Hotel, Peoria, Ill., Sept. 19, 20, 21, 1951, under the Presidency of Dr. Ralph McReynolds of Quincy, Ill. Clinical teachers from the leading medical schools will conduct this postgraduate assembly whose program is planned to appeal to general practitioners. There will be scientific and technical exhibits, noon round-table luncheons, etc. No registration fee will be charged and every ethical physician is cordially invited to attend. The program and exhibits will be held in the Pere Marquette Hotel. A program of the meeting may be obtained from Harold Swanberg, M.D. Secretary, 209-224 W.C.U. Bldg., Quincy, Ill.

M. L. BLATT MEMORIAL FUND LECTURE

The Pediatric Staff of the Cook County Hospital announces the third Maurice Lamm Blatt Memorial Fund lecture by Dr. Irvine McQuarrie, Professor and Head of the Department of Pediatrics, University of Minnesota, who will talk on "Clinical and Experimental Studies on Hypoglycemia".

This lecture will be given Tuesday, October 2, 1951 at 8:30 P.M. in the Medical Amphitheatre of the Cook County Hospital. All interested physicians are invited to attend.

Very sincerely yours,
M. A. Perlstein, M.D.
Chairman of the
Maurice Lamm Blatt Memorial Fund
Committee

CHEST PHYSICIANS MEETING

The 17th Annual Meeting of the American College of Chest Physicians was held at the Ambassador Hotel, Atlantic City, New Jersey, June 7 through 10, with a registration of 1040. On Saturday, June 9, at the administrative session, the following officers were elected for the coming year:

Dr. Chevalier L. Jackson, Philadelphia, Pennsylvania, President; Dr. Andrew L. Banyai, Milwaukee, Wisconsin, President-Elect; Dr. Alvis E. Greer, Houston, Texas, First Vice-President; Dr. William A. Hudson, Detroit, Michigan, Second Vice-President; Dr. Minas Joannides, Chicago, Illinois, Treasurer; Dr. Charles K. Petter, Waukegan, Illinois, Assistant Treasurer.

At the Convocation ceremony held on Saturday, June 9, 109 physicians received their Fellowship Certificates. Oral and written examinations for Fellowship in the College were given to 58 physicians on Thursday, June 7. Dr. Darrell H. Trumpe of Springfield, was elected Governor of the College for the state of Illinois. Dr. Otto L. Bettag of Chicago, was re-elected as Regent of the College for District No. 7.

PERNICIOUS ANEMIA IN THE NEGRO

In the June issue of the ILLINOIS MEDICAL JOURNAL an article by Coffman, Slavin and Hartnett on "Pernicious Anemia in the Negro" reports two cases. The article implies a review of the literature and suggests that pernicious anemia in the negro is quite rare.

Under the title of "Pernicious Anemia in Negroes", ARCHIVES OF INTERNAL MEDICINE, December, 1943, we reported 93 cases and added them to a previously reported 106 and pointed out that pernicious anemia in the negro was not rare but was apparently being commonly overlooked.

I consider it unfortunate that once corrected misconceptions be allowed to recur in the literature.

Yours sincerely,
Steven O. Schwartz, M.D.
Director
Hematology Laboratory
The Hektoen Institute for
Medical Research of the
Cook County Hospital

GOVERNOR'S CONFERENCE ON EXCEPTIONAL CHILDREN

Plans for the Eighth Governor's Conference on Exceptional Children are now being formulated, it was announced by Jane Bull, Executive Director of the Illinois Commission for Handicapped Children.

The Conference, held annually by the Commission, is scheduled for Friday, September 28, at the Stevens Hotel, Chicago. The program and speakers will be announced at a later date.

The 1951 ANNUAL MEETING

For the first time in many years, the Illinois State Medical Society met at the Sherman Hotel in Chicago. The meeting was successful from the standpoint of both the physicians and the exhibitors, with a total registration of 3,077.

Exhibitors particularly played an important part in presenting constructive suggestions for future meetings which the Society hopes to observe. These pictures give you highlights of the meeting which you may not have been able to attend.

The 1952 meeting is scheduled for Chicago, and the editor hopes these pictures will prompt your attendance.

(Staff Illinois Medical Journal Pictures)



Here is that historic moment again. Harry M. Hedge of Chicago, retiring President, hands the gavel to C. Paul White of Kewanee, when the latter assumed the presidency.



Two new members of the Council are Burtis E. Montgomery, Harrisburg (9th District), and Willard W. Fullerton, Steeleville (10th District). They replace Charles O. Lane of West Frankfort, and G. C. Otrich of Belleville, both of whom gave many years of service to the Society.





Walter Bornemeier, Secretary of the Chicago Medical Society, is obviously pleased that his nomination for president elect has been approved. Here he is with the President Elect, Leo P. A. Sweeney of Chicago.

(Far Right) Two new members of the Council from the 3rd District, R. C. Oldfield of Oak Park, and John L. Reichert of Chicago.



At the Annual Dinner, Walter Stevensan, a past president of the Saciety, acted as Taastmaster. In the center are, the President, Harry M. Hedge, and the principle speaker, Danald J. Cawling, President Emeritus, Carletan Callege, Narthfield, Minnesata. At the right is Charles P. Blair, Chairman af the Council. Mr. Cowling's address was entitled "Our American Heritage".



As usual, the Annual Dinner was "sald out". A typical table included (left ta right) Elmer McCarthy, Frank Hammond, Mrs. Hammand, Earl Miller af San Francisca, and Warren Furey. The dactar whase glasses and farehead are visible just past Dr. Furey is Willard C. Smullen af Decatur.



Mare active than it has ever been in the past, the Women's Auxiliary af the Illinais State Medical Saciety was ably represented at the Annual Dinner by Mrs. James McDannough af Chicaga, President, and Mrs. Carl E. Sibilsky of Pearia, the retiring President.





Here is that perennial lively graup, the Fifty-Year Club. (abave) Andy Hall af Mt. Vernan, E. E. Davis af Avan, and J. S. Templetan af Pinckneyville. It is hardly necessary ta add that Andy was named the autstanding general practitianer af Illinais and af the cauntry in 1950. E. E. Davis was Illinois' naminee far the same title in 1951.

At the lunchean (left) were Dr. I. B. Diamand af Chicaga, Mrs. and Dr. Gea. H. Miller af Bellaire, Dr. Henry J. Hillebrand af Chicaga, Dr. F. B. Knudsan af Chicaga, Dr. S. Hawell af Elgin, and Dr. Andy Wyant of Chicaga.





It is difficult to believe that each year's Fellowshi Hour can better the last, but it is true. F. M. Nicholso and Albert Mickow (left) planned the best the Societ has ever had. Most of you will recognize J. J. Moor in the picture above, Treasurer of the AMA. He is ob viously having a good time. So did hundreds of other Technical exhibitors also joined the party.



There were 89 technical exhibitors, most of whor declared their satisfaction with the meeting. At lef Chester Peters of the Upjohn Company seems to hav told one of his famed stock of stories. In any cas everybody seems happy.



This is a picture (lower left) that cannot be explaine other than to say that there was a crowd around th booth. Eli Lilly has exhibited at our meetings for year



These are the people that you seldom see at t meeting, but they are important, for they are on t Secretary's staff and arrange many of the things y enjoy. (left to right) Rita Sherwood, Public Relatio Assistant, Jane Swanson, Webb Johnson, and Franc Zimmer, Assistant Secretary.





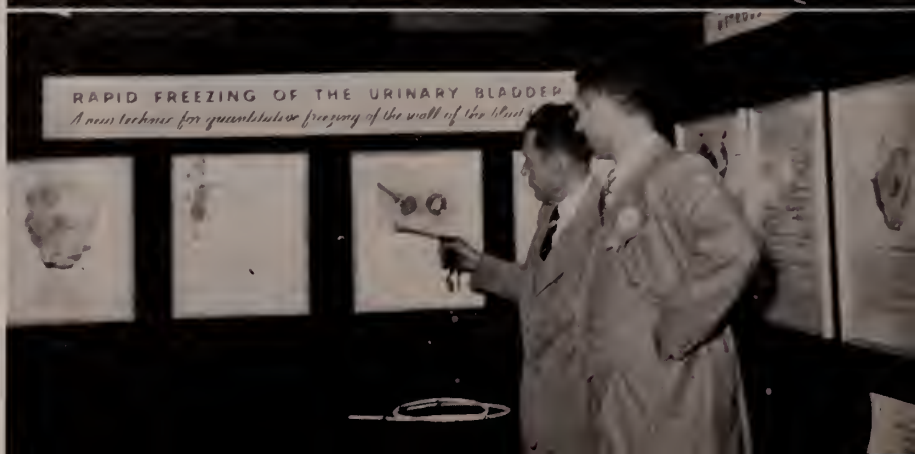
There were 37 scientific exhibitars. Awards were given to two graups, one far original work and the ather far exhibits af technical value. In each group gold, silver, and branze medals were given. Dr. Coye C. Masan said he had more applications for space than he could accommodate, and added that twelve of the exhibits went on to the meeting af the AMA at Atlantic City.

Karl Singer and Amaz I. Chernoff of Chicaga were awarded the gald medal for their ariginal exhibit, "Pathogenesis af Sickle Cell Anemia and Other Hereditary Hemalytic Syndromes".

"Congenital Heart in Pediatrics. Based an Study af 700 Cases", by Benjamin M. Gasul, Egbert H. Fell, William P. Mavrellis, Maurice Lev, Oldrich Prec, and Raul Casas, all of Chicago, received the gold medal for educational value.



The silver medal for educational value went to Frederick H. Falls and Charlotte S. Halt of Chicago for their exhibition an "Pregnancy in Bicornuate Uterus."



The exhibit af James H. McDonald, C. Bruce Taylor, Narris J. Heckel, and W. A. Rosso, Chicago, "Rapid Freezing of the Bladder", was awarded a silver medal.

ORIGINAL ARTICLES



The Diagnosis and Treatment of Endometriosis

James P. FitzGibbons, M.D., F.A.C.S.
Chicago

In 1899, William Wood Russell described a case of endometrial tissue found in the ovary. Since that time, a voluminous literature on endometriosis has been gradually accumulating. Possibly the first exhaustive study was that reported in 1921 by Dr. John Sampson of Albany, New York. Other pioneers were Ivanoff, von Recklinghausen, Robert Meyer, Thomas Cullen, Emil Novak, and within the last decade the names of Counseller, Meigs, Goodall, and Fallon are conspicuous.

However, in spite of over a half century of scientific study and speculation, the exact causation remains obscure and the protean manifestations of this strange disease cannot yet be fully accounted for by any one particular hypothesis. Briefly, the prevalent explanations to date are: (1) transtubal reflux with subsequent implantation, (2) metaplasia, (3) activation of fetal rests, (4) lymphatic or venous metastases.

Presented before the General Assembly, Illinois State Medical Society, 110th Annual Meeting, Springfield, May 23, 1950.

The term "endometriosis" quite aptly fits the disease entity when used in conjunction with the name of the affected site. Adenomyosis, which is endometriosis of the uterine wall or so-called internal endometriosis, occurs in a later age group, is only infrequently associated with sterility and is perhaps, as is felt by some, a distinct disease.

Endometriosis is a specific disease and may be defined as the ectopic presence of endometrial tissue morphologically and physiologically similar to that lining the uterine cavity.

The presence of ectopic endometrium has been reported found in a multiplicity of sites, viz., uterine wall, all the pelvic organs, the peritoneal surfaces, the cervix, vagina, vulva, abdominal and perineal scars, the umbilicus, and even the kidney and lungs. It is infrequent prior to the age of 25 and after the menopause, thus being a disease affecting women mainly during the reproductive span of life.

The present paper is based upon a study of the literature and an analysis of 182 cases of

endometriosis found among 4,483 pelvic laparotomies performed by the staff of a 280 bed, nonsectarian, general hospital from 1940 to 1949. All patients were white.

In 161 cases the diagnosis was positively confirmed by histological study of the surgical specimen; the remaining 21 were either serosal implants or "chocolate cysts" in which the diagnosis was only presumptive. Including the presumptives, the over-all incidence was 4 per cent. If only those with positive histological findings are considered, the incidence then is 3.6 per cent. These figures are at variance with those of Meigs who found an average incidence of 16.9 per cent among 800 laparotomies.

Age Distribution

Age	*Number*
15 - 19	2
20 - 24	5
25 - 29	19
30 - 34	34
35 - 39	42
40 - 44	33
45 - 49	36
50 - 54	10
55 - 59	1

145 or 79 per cent occurred in women between the ages of 30 to 49 years. The youngest was 16 and the oldest 57 years. These figures, like most statistics, could, however, be misleading as the reason for laparotomy in most instances was associated with other found pathology. In 59 or 32.4 per cent the endometriosis was confined to the uterus — the so-called adenomyosis or internal endometriosis, and only 8 or 13 per cent of these 59 cases were under 35 years of age as contrasted with 33 per cent under 35 years in the entire series. In other words, internal endometriosis seems to affect women in the latter half of the reproductive years. Again the statistics are misleading for the finding of incidental adenomyosis would naturally be higher over the age of 35 since the incidence of laparotomy also is higher in this age group. Lewinski has reported that 53.5 per cent of all uteri examined at necropsy showed evidence of adenomyosis and considers the condition almost physiological.

Of the 182 cases upon which this study is based, 154 were married and 57 of these had never been pregnant, a sterility incidence of 36 per cent, whereas the accepted incidence of involuntary sterility in the general population is estimated to be not more than 15 per cent. Again, associated pathology could well account for this decrease in fertility. It is interesting to note that 81 per cent of the patients with adenomyosis were fertile! Meigs has repeatedly stated that endometriosis is an economic disease, basing his assertions on the fact that the condition is found in much greater frequency in private patients than in clinic patients. Of 400 private patients subjected to laparotomy, 28 per cent were found to have endometriosis, whereas the incidence was but 5.8 per cent in 400 clinic patients. In his contributions, Meigs fails to mention race as a factor. It is well known in this author's experience at the University of Illinois Research and Educational Hospitals Dispensaries that a case of suspected endometriosis in a colored patient is very unusual and the incidental finding of endometriosis at laparotomy at the same institution, where the vast majority of patients is colored, is less than one per cent. Just as the colored race seems to possess a certain immunity to vaginal relaxations and descensus uteri, such might be the case in endometriosis. Inasmuch as the colored people usually live at a substantially lower economic level perhaps then it is racial rather than economic factors which account for the evident disparity in incidence.

The incidence of the disease has been thought by some to have increased with civilization but, like so many other diseases, the increase may be more apparent than real because of the more extensive search and finding of present-day medicine. In the event that periodic menstruation, uninterrupted by pregnancy, may be a factor in the production of endometriosis, then certainly concomitant with civilization, long deferrred marriage and postponement of conception are definite factors, as stated by Meigs.

Areas of ectopic endometrium, during the reproductive span, are subject to hormonal influences in periodic fashion just as is the normally located tissue, and undergo similar cyclic changes. Initially a lesion may bleed into the peritoneal cavity and by irritation stimulate fibroblastic proliferation about itself, thus tending toward encapsulation. Until the latter occurs the phenomenon may be painless; however, with progression, the increased fluid encysted as it is,

causes pain referable to the affected site and concomitant with the regular menstrual cycle. Such a cyst may increase in size and eventually cause a pressure obliteration of the endometrial tissue lining so that subsequent examination of the surgical specimen may show no evidence of endometrial tissue, but merely a so-called chocolate cyst. Another possible outcome is perforation of the cyst wall with spillage of the contents and reimplantation elsewhere in the peritoneal cavity. Minute perforations may very well be asymptomatic but sudden large perforations are apt to simulate the acute surgical abdomen. That endometriosis has invasive properties is well known. It might well be called a benign neoplastic disease. When extensive, it may simulate carcinoma especially when the site affected is the rectum or sigmoid colon. The adhesions produced are not, as in coccal pelvic inflammatory disease, mere agglutinations of serous surfaces which can usually be readily separated with the finger, but because of the invasive tendency the organs involved may be found to have grown together and separation cannot readily be performed surgically even by the expert. Surgical manipulation is frequently fraught with danger of injury to vital structures.

The symptomatology is directly dependent on the site affected and the extent of involvement.

The Sites and Frequencies of Endometriosis in 182 Laparotomies:

Uterus (adenomyosis)	62
Two ovaries	43
One ovary	41
Pelvic peritoneum	26
Adenomyosis and ovaries	9
Fallopian tubes	7
Bladder peritoneum	4
Rectal peritoneum	4
Sigmoidal surface	2
Broad ligament	2
Rectosigmoid	2
Laparotomy scar	1
Cesarean scar	1
Rectus sheath	1

It is very likely that most cases of uncomplicated endometriosis are completely asymptomatic and if and when the patient applies for aid it is because of either infertility or symptoms caused by associated pelvic pathology. Again the lesion may be quite extensive and yet the patient be symptom-free. However, in the average case of pelvic endometriosis, a patient will present herself complaining of symptoms whose severity is completely out of proportion to the findings on examination.

Dysmenorrhea is prominent in all references to the disease and the incidence has been variously reported from 30 to as high as 60 per cent. This variation may be accounted for somewhat by the fact that a standardized definition of the word itself is lacking. Thus, a back ache at the time of menstruation may be considered by some observers to constitute dysmenorrhea and yet may be ignored by others. Again a patient may consider back ache to be the common lot of all menstruating women and even fail to mention its existence at the time of history taking. Certainly we are all aware of the marked variation in levels of pain thresholds. Again the discrimination between the essential dysmenorrhea that has been recurring since the menarche and the superimposed pain acquired as the result of the lesion of endometriosis may be impossible.

In the present series, painful menstruation was the complaint of 62 patients, an incidence of 34 per cent, and the duration was one year or less prior to application for care in 90 per cent of these. Because the cases in the present study are based on information obtained from hospital histories written by interns, with only occasional added notes by the attending physicians, there has been little elaboration of the symptom dysmenorrhea in the majority of instances. Perusal of the material available brings out the following points: the pain of menstruation is located in one or both lower quadrants of the abdomen; of 62 patients, 20 complained of lower abdominal pain; 16 of right lower quadrant pain; 5 of left lower quadrant pain; a total of 41 patients who localized the pain in the abdomen. The pain begins simultaneously with the flow; it persists throughout the flow; it is not relieved by the analgesics ordinarily used for dysmenorrhea; nor is bed rest of much value.

Adenomyosis alone is an infrequent cause of dysmenorrhea, accounting for only 25 per cent of the 62 cases in the present series. In 110 or 60 per cent of 182 cases the endometriosis affected one or both ovaries and/or the pelvic peritoneum. In approximately 50 per cent of these, the patient did not complain of dysmenorrhea.

Endometriosis may occur in the cul-de-sac and extend by invasion into the rectovaginal septum and on rare occasions into the vagina itself. The ovaries, being frequently affected, may because of increased size and weight sometimes gravitate into the cul-de-sac and become adherent. The pelvic peritoneum may be the site of implants anywhere. Any one of these several locations of lesions could very well result in dyspareunia. Either because of modesty or perhaps because the intern failed to ask the question, this latter symptom is often difficult to elicit. In the present series it was found in but three cases in the presenting complaint. Dyschesia, or painful or urgent defecation, was a presenting complaint in ten and dysuria was found in seven.

Since the disease is invasive and progressive, the time eventually arrives when pain persists even during the interval phase.

Menorrhagia, meno-metrorrhagia and hypermenorrhea are frequently found as a presenting complaint in most series of cases of endometriosis, but such a symptom cannot be explained on the basis of the lesion of endometriosis per se, and is usually due to the presence of associated pathology. 69 or 38 per cent of the present series were troubled with such a symptom and it might be interesting to note than in one-half of these patients adenomyosis was present with or without other pelvic pathology.

Other symptoms are dependent entirely on the particular structure involved and the extent of the lesion. Implants on the small bowel, the peritoneal surfaces of the bladder, the rectum and the rectosigmoid are, as a rule, asymptomatic except when because of the invasive nature of the disease the lesion penetrates beyond the serosa and involves the muscular layers of these organs. Invasion usually limits itself short of the mucosa but a sufficient number of cases have been reported describing so-called vicarious menstruation from both the bladder and the bowel to make such limitation of growth questionable. Thus, both melena and hematuria could be included in the syndrome but only as corroborative evidence and certainly not forgetting the more common and more serious causes of such findings. The invasion of the rectum and rectosigmoid may well simulate a scirrhous form of carcinoma and produce obstructive symptoms. The roentgenologic and proctoscopic examinations are of some aid here but are frequently difficult of interpretation.

Routine laboratory procedures are of no significant diagnostic value and as yet no specific tests for the disease have been devised.

Pelvic examination findings depend, of course, on the site and extent of the lesions. When the findings on bimanual and rectovagino-abdominal examination are minimal and the symptoms seem disproportionately severe, endometriosis should certainly be suspected. More thorough palpation of the cul-de-sac, rectovaginal septum and uterine ligaments may reveal nodules of varying size that are tender and the pain elicited may be a simulation of the pain of which the patient complains. Re-examination at the time of menstruation may substantiate these findings either by the detection of increased size or increased tenderness. Degrees of fixation or loss of mobility of the uterine ligaments, a loss of pliability of the pelvic peritoneum, intense pain on motion of the uterus and/or adnexa in the absence of palpable masses, all lead one to suspect the presence of endometriosis.

Although I have had no personal experience with culdoscopy, I have spoken to Dr. Joseph Teton of Chicago regarding its diagnostic value in endometriosis. Dr. Teton informs me that once the technique is acquired, typical endometrial lesions on the ovaries, tubes, posterior broad ligaments, pelvic peritoneum, rectum, sigmoid, small bowel, the appendix, and even the superior border of the urinary bladder, when the latter is distended, may be visualized. This diagnostic instrument should in time become of inestimable value in the early diagnosis of the disease.

Inhibition of ovulation by means of the exhibition of the androgenic or estrogenic hormone has been advocated as a therapeutic procedure by Miller and others. Regardless of the value of such therapy, it is of definite use in diagnosis since, if the symptom complex can be ameliorated by the inhibition of ovulation and menstruation, the chances are good that the lesion is one of endometriosis. Meigs now reports a preoperative diagnosis rate of 41 per cent which demonstrates the results that can be achieved when one exerts painstaking thoroughness in history taking and examination.

The management of endometriosis begins as in most diseases — with prophylaxis. Certainly

the apparent increase in the incidence of the disease must be due to a limited extent to the fact that women today are more informed than their counterparts of 20 years ago and are seeking medical advice and aid sooner and in greater numbers, and the diagnostic acumen and armamentarium of the physician have gone on apace.

Whether late marriage and still later conception is a factor, auguring for an increase in the disease, is debatable. However we do know that early marriage and early conception is natural in the animal world. Perhaps federal subsidy, as advocated by the recent Axis regime, is not democratic but parental subsidization of young couples, as suggested by Meigs, might be in order. Certainly it is agreed that pregnancy inhibits menstruation and thus checks progression.

It is probably true that the gridiron incision is preferred for appendectomy by most surgeons because of the lessened chance of postoperative herniation and wound disruption; however, as Fallon points out, it might be advisable that an incision allowing for adequate pelvic exploration be used in all women who are in the reproductive age and who have not conceived during the previous five years.

Gentleness in handling tissue is a prerequisite of surgical technique and is of paramount importance in female pelvic surgery. Caution should be the key word in the performance of curettage and tubal insufflations. The latter should preferably be done seven to ten days following the cessation of flow.

The laity should be taught that periodic physical examinations, including pelvic examination, are essential to the preservation of good health and the prevention of disease.

The active management of endometriosis is surgical. Medical management, such as the administration of androgens and estrogens, should be reserved for the treatment of recurrences. Menolysis by means of x-ray radiation during the reproductive years, as has been performed by Schmitz, cannot with certainty, be considered to be not without danger to the germ plasm. This form of therapy, therefore, should also be reserved for the treatment of recurrences. Full castration dosages may be used in the treatment of patients at or near the menopause if it is felt that such treatment will suffice to arrest progression of the disease.

In the surgical treatment of endometriosis, many important factors should be taken into consideration; viz., age, marital status, fertility, the severity of the symptoms. Symptoms require expert evaluation by the attending physician. Is reproductive function and/or feminine psyche to be preserved?

Prior to any exploratory laparotomy for suspected endometriosis, the patient should be informed that procedures more radical than anticipated may be carried out and there should be a perfect understanding regarding this matter between patient and surgeon.

If retention of ovarian function with the presumed consequent preservation of feminine psyche is used as a criterion, the incidence of conservative surgery in the present series is 86 or 47.2 per cent. However, if preservation of reproductive capacity is used as the gauge, the figure is reduced to 36 or only 19.7 per cent. If childbearing capacity is used as the criterion, then, for obvious reasons, women past 40 may be eliminated. In this event, the incidence of conservative surgical procedures becomes increased to 31 or 30 per cent.

In the largest series of cases yet reported in the literature, Counseller of the Mayo Clinic states that 162 or 18.3 per cent of 884 cases were treated by conservative surgery and 21 by radiation. However, he does not state whether the preservation of the reproductive function or the mere preservation of the feminine psyche was the criterion of conservatism. Other authors have reported a conservative type of operation in as high as 94 per cent. Certainly each case is an individual one and must be so evaluated. At the time of laparotomy, tuberculosis and malignancy must be differentiated. Endometriosis being neoplastic invades various organs, thus completely obliterating the cleavage planes usually found when invasion is absent. It is this invasion which frequently precludes adequate surgical orientation. Proper surgical extirpation of the involved organs is thus made exceedingly difficult and the risk of serious injury to the rectum, ureters, bladder and other pelvic structures is high. When the surgical difficulties seem insurmountable one should be satisfied with mere castration.

In the young woman desirous of having children every effort should be made to preserve the reproductive function. This may mean partial resection of one or both ovaries, resection or fulguration of endometrial implants, hysteropexy and possibly presacral neurectomy. When a conservative operation is planned it is always wise to perform a dilatation and curettage prior to the laparotomy so that in the event of preservation of the uterus the operator will feel more secure with the knowledge that a normal organ is being retained, and the dilatation may possibly be effective in reducing the severity of any postoperative dysmenorrhea. Most surgeons have performed radical procedures in order to preclude the necessity of re-operation. As has been stated earlier, recurrences may be adequately treated by means of androgens or x-ray radiation and certainly it is no crime to re-operate especially when the patient has been previously warned of such a possibility.

Among patients who are at or approaching the menopause, except in very unusual cases, the thought of conception is remote and the possibility is even more unlikely so that, when surgically possible, complete extirpation of the uterus and adnexa should be the procedure of choice. It is in the extensive pelvic endometriosis that discretion is the better part of valor. If the cervix is diseased certainly it is wise to remove it. However, in the event that dense adhesions, so characteristic of endometriosis, have invaded the cul-de-sac and parametria and the uterovesical peritoneum, it may be impossible without risking the integrity of the rectum, bladder and/or ureters to attempt to completely remove the uterus. In the event that total removal of ovarian tissue remains questionable in the surgeon's mind, it may be much wiser to treat by postoperative irradiation rather than inadvertently injure vital structures.

Resection of the bowel is to be performed only for obstruction. Ablation of ovarian function either surgically or by radiation should be effective in causing regression of bowel lesions.

CONCLUSIONS

1. The cause of endometriosis remains obscure.

2. The disease was found in 182 of 4,483 pelvic laparotomies, an incidence of 4.1 per cent.

3. Women in the late reproductive span are most frequently affected, 79 per cent occurring between the ages of 30 and 50 in the present series. The youngest was 16 and the oldest 57.

4. The uterus and ovaries are the sites of predilection, 80 per cent of this series.

5. Adenomyosis was present in 32.4 per cent.

6. Sterility existed in 36 per cent, almost double the accepted involuntary sterility rate of the general population. 81 per cent of the patients with adenomyosis had been pregnant!

7. The disease is infrequent among the colored race.

8. Pain is the outstanding clinical symptom, its character depending on the location and extent of the lesion. It may be more severe than the findings eventually warrant. It is usually localized by the patient to the lower abdomen. Dysmenorrheal pain was present in 34 per cent and was aggravated rather than relieved as the flow progressed.

9. Menorrhagia and hypermenorrhea were present in 38 per cent but usually attributable to some associated pathology.

10. Culdoscopy should prove valuable in early diagnosis.

11. Inhibition of menstruation by androgens or estrogens may be used as a diagnostic aid.

12. During abdominal operations for other indications, the pelvis should be explored in order to detect the disease in its early stage.

13. The active treatment of endometriosis is surgical. In patients under 40, every effort should be made to preserve the reproductive function and/or the feminine psyche — 30 and 51.9 per cent respectively in the present series.

14. Recurrences are not infrequent after conservative procedures but may be adequately managed with androgens or radiation or possibly re-operation.

I wish to thank the Medical Staff of Grant Hospital, Chicago, Illinois, for the privilege of surveying their private case records, and Mrs. George Waterstraat, Jr., Director of the Medical Records Library of Grant Hospital, for her help in compilation of these statistics.

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Indications for Surgery in Gallbladder Disease

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Gallbladder disease is one of the most common indications for surgery. No doubt, in the future, surgery of the biliary system will be even more common. Vital statistics show a difinite increase in the span of life, and it is in the elderly that the incidence of gallbladder disease reaches its peak.[1] Although the morbidity and mortality rate of biliary surgery has steadily improved, there are many patients in all age groups who are hesitant to accept the recommendation of surgery. This unsatisfactory situation arises in part from the mistaken belief that disagreeable symptoms commonly persist after removal of the gallbladder. In addition, many physicians are hesitant to advise operative intervention for the same reason. It must, therefore, be accepted that enough of these 'symptomatic' failures have occurred in the past to influence many physicians as well as patients. Because uniformly good results can be obtained from biliary surgery, every physician should review from time to time all aspects of his own management of gallbladder disease. Improvement in the end results will follow if the symptoms of the patients selected for surgery arise from disease of the gallbladder or its ducts, and if the operation is thorough and complete.

Because the diagnosis of gallbladder disease is so easily confirmed by means of cholecystogram, this method of examination is utilized routinely for guidance in the selection of patients for operation. The best results follow surgery in the patient who has gallbladder colic and in whom gallstones are demonstrated by cholecystogram.

The indications are less clearly defined in a large group of patients in whom the gallbladder does not fill by cholecystogram and no stones are

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visualized. Surgery is not recommended in this group unless there has been a history of typical gallstone colic severe enough to require narcotics. Even under these circumstances, a repeat cholecystogram with reinforcement of the dye is very desirable.

One of the pitfalls in the selection of patients results from the acceptance of a non-filling gallbladder on one test as an absolute indication for operation. This is especially true in the presence of only mild digestive symptoms. These patients should be carefully questioned regarding the amount of dye ingested and retained. It should be remembered that some patients will fail to take all of the gallbladder dye as prescribed or may vomit a portion of the ingested dye. Similarly, in the presence of gastric retention from any cause or in delayed absorption in a variety of conditions, a normal gallbladder will fail to visualize. For these reasons the dye should be reinforced and the cholecystogram repeated. If the gallbladder fails to visualize at the time of the second examination, surgery may be recommended providing the symptoms are of sufficient severity and a complete x-ray survey of the gastrointestinal tract has been non-contributory. Too much emphasis has been placed on poor filling, delayed emptying, or an unusual size or shape of the gallbladder as shown by cholecystogram. In such instances cholecystectomy is not advised unless the patient has had repeated attacks of gallbladder colic. However, we have observed patients with apparent normal cholecystograms who continued to have repeated attacks of severe colic. Despite the negative findings by x-ray examination, very small calculi were found at the time of cholecystectomy and relief of symptoms was obtained. It should be noted that cholecystography is of limited value in the presence of jaundice because of interference with the concentration of the dye for a variety of reasons.

There is no better way to improve the results in biliary surgery than to avoid operating upon those patients with vague symptoms and questionable evidence of gallbladder disease as shown by cholecystogram.[2] More and more we have insisted upon a complete gastrointestinal survey, despite clear cut evidence of a diseased gallbladder by cholecystography. The frequency of more serious associated pathology has often demonstrated the wisdom of such thorough routine studies. Included among these are hiatus hernia, benign or malignant lesions of the stomach, carcinoma of the large bowel (especially the cecum) and, more rarely, pancreatitis.

Heart disease must also be considered as a cause of the patient's symptomatology. The initial distress from gallstone colic as well as coronary heart disease is frequently referred to the epigastrium or substernal region and may be associated with shortness of breath. Such symptoms manifest in the middle of the night, may be confusing to the physician accustomed to the more classical picture of gallbladder disease, and may account for some delay in accurate diagnosis.

Gallbladder disease not only mimics but may coexist with (and at times intensify) heart disease by precipitating congestive failure or aggravating attacks of angina pectoris. Although many physicians and most patients consider cardiac disease as a contraindication to surgery for biliary disease, cardiologists usually believe it beneficial to remove a diseased gallbladder even though the patient has had a previous coronary thrombosis. In our opinion, cardiovascular disease does not alter the surgical indications in acute cholecystitis, in recurrent colic from a diseased gallbladder, or in suspected common duct stone. These patients do exceedingly well if sufficient time is taken to properly stabilize the cardiovascular system prior to operation. We have found the daily determination of vital capacity to be of great assistance in determining the optimum time for surgery in the 'poor-risk' cardiac. It has been our policy to delay operation until the vital capacity exceeds 1500 cc., and we prefer to see it greater than 2000 cc.

Twenty-eight patients with advanced cardiovascular disease have been operated upon in the University Hospital in the past three years. This is approximately one patient in ten submitted to gallbladder surgery. The operative procedure was well tolerated in each instance, even when exploration of the common duct was included. There were no deaths in this group, although almost one-half of these patients were more than sixty years of age.

There is no more grateful postoperative patient than the 'cardiac' who has suffered repeated attacks of gallbladder colic over a period of years, and who has been previously denied

the benefits of surgery because of the unwarranted fear on the part of the physician that the risk was too great. Furthermore, it is not uncommon to have the so-called 'cardiac symptoms' disappear after operation. The increasing age of our population makes this problem especially important.

Another controversial problem is the management of these patients with 'silent gallstones.' This group includes those patients in whom gallstones have been unexpectedly discovered either at the time of laparotomy for other disease or as a result of a complete survey for vague gastro-intestinal complaints. Some physicians feel that a policy of "watchful-waiting" gives the best results. Others have questioned this attitude of accepting 'silent gallstones' as essentially harmless to the patient because so many eventually develop a complication. The higher morbidity and mortality associated with complications of gallstones, particularly in the elderly, should raise the question whether procrastination is actually safest and most satisfactory or whether gallstones should be removed prophylactically.

In deciding whether cholecystectomy is in the best interest of the patient, the physician may be influenced by a number of factors. What are the size and number of the stones? Small stones which might obstruct the cystic duct or escape into the common duct are more likely to cause serious difficulties than the large solitary calculus. Are there symptoms from the stones? The physician must be constantly on the alert for the confirmed psychoneurotic with a gastric neurosis, which originally led to the gastrointestinal survey and demonstration of the gallstones. If a cholecystectomy is recommended in the hope of relieving all symptoms in such a patient, both physician and patient are doomed to disappointment. Will surgery benefit associated disease? Management of an intractable duodenal ulcer is frequently simplified following removal of a diseased gallbladder since the ulcer type diet is more readily tolerated. Pancreatitis is frequently associated with biliary tract disease, and if recurrent, points strongly towards the presence of a common duct stone.[3] The benefits to be expected in those patients with associated heart conditions have been stressed previously. Can the surgical risk be lessened? Gallbladder disease is frequently found in the overweight. Since there is a certain amount of surgical risk associated with obesity it is always well to institute a weight reduction program for such patients before surgery is undertaken.[3]

Finally, if surgery is withheld, will there be future complications? The well known trend of the general population toward higher age levels, together with the fact that the incidence of complications arising from gallbladder disease increases with each decade of life, makes it doubtful whether delay is actually safer for the patient. Analysis of our experience with gallbladder disease over the past three years has produced some interesting and informative results regarding this question.

The first step was to estimate the hazard of the two more common complications in each decade of life; acute cholecystitis and common duct stone. A total of two hundred and thirty-one consecutive cases operated for gallbladder disease at University Hospital over the past three years were analyzed. As Figure 1 shows, age groups from 20 through 59 showed no significant departure from the average incidence of acute cholecystitis. In these age groups, the incidence was actually lower in most instances. In contrast to this, there was a distinct increase in the incidence of acute cholecystitis with each decade of life in those patients 60 years or older. Similar results were obtained for com-

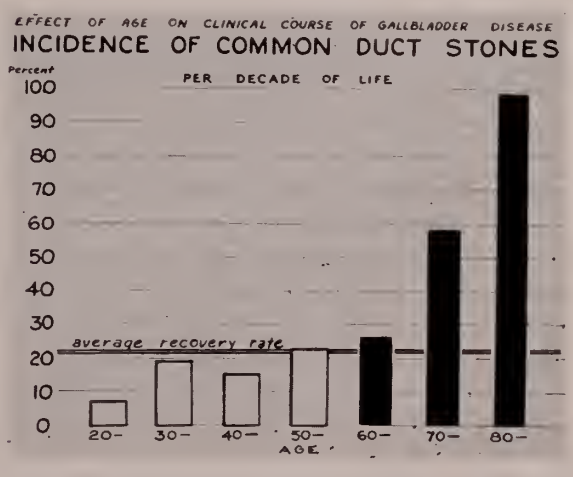


Figure 1. Incidence of acute cholecystitis per decade of life in 231 consecutive cases operated at University Hospital for gallbladder disease over a three year period.

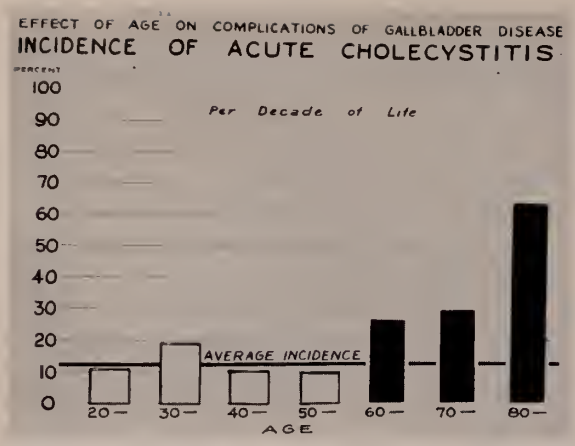


Figure 2. Incidence of common duct stone per decade of life in 231 consecutive cases operated at University Hospital for gallbladder disease over a three year period.

mon duct stone (see Figure 2). Surprisingly enough, the average recovery rate for common duct stone was almost realized in those patients 30 to 39 years of age. With this exception, the incidence of common duct stone increased steadily with each decade of life, approximating the average recovery rate of age 50. Once again the most marked increases were noted in those patients over 60 years of age.

Another, and more serious lesion to be considered as a potential complication of gallstones, is carcinoma of the gallbladder. The overall occurrence in this series approximate 2.5 per cent; however, this incidence increased to more than 9 per cent in those patients 60 years of age or older. Gallstones were demonstrated in 5 of the 7 cases operated upon. Cholelithiasis is found either at operation or at autopsy in 70 to 80 per cent of those cases with carcinoma of the gallbladder.[4] Perhaps this should influence the physician to consider early cholecystectomy for gallstones, not only as a means of correcting associated symptoms or preventing later complications of acute cholecystitis and common duct stone, but also as a prophylactic measure against malignant transformation.

It is noteworthy that 76 or 30 per cent of the 238 patients operated upon for gallbladder disease were 60 years of age or more (Figure 3). As previously emphasized, the incidence of complications in this group was much greater than the group as a whole. Three out of every four patients over 60 years of age came to surgery because of some complication of their gallbladder disease. These included in order of frequency: common duct stone, 1 in 3; acute cholecystitis, 1 in 4; acute pancreatitis, 1 in 10; carcinoma of the gallbladder, 1 in 11. Since patients with complications usually give a history of multiple attacks it would seem that earlier operation would not only have reduced the operative risk but would also have spared the patient much distress. These facts, together with the increased life expectancy, justifies advising the middle-aged patient that he stands a good chance of living long enough to develop serious trouble from his gallstones, necessitating operation at a later date and entailing greater risk.

One of the common serious risks of gallbladder disease is acute cholecystitis. Although three out of four patients suffering an attack of acute cholecystitis will respond promptly to conservative management in the home, the remainder fail to subside or show rapid progression and surgical intervention becomes mandatory. Since future complications are unpredictable, routine management is not satisfactory, and each case must be hospitalized as soon as the diagnosis is suspected.

Following estimation of the severity of the inflammatory process, the usual measures are

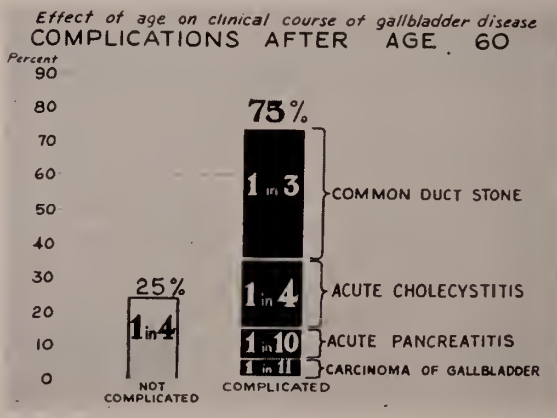


Figure 3. Seventy-six or 30 per cent of 238 consecutive patients operated for gallbladder disease were 60 years of age or more. Of these, three out of every four came to surgery because of some complication of their gallbladder disease. These included in order of frequency: common dust stone, acute cholecystitis, acute pancreatitis and carcinoma of the gallbladder.

taken to relieve pain and establish fluid and electrolyte balance. No striking benefit is to be expected initially with antibiotics due to the fact that acute cholecystitis so often results from chemical irritation following sudden occlusion of the cystic duct rather than bacterial invasion. The optimum time for operation depends on the severity of the disease process and the response to treatment. This calls for frequent reevaluation both by means of bedside visits and by laboratory aids. The possibility of surgery must be considered whenever there is an unfavorable change in the vital signs, the white blood count and the abdominal findings.

Signs of generalized peritonitis calls for surgical intervention as soon as the patient's condition permits.

Those patients whose signs and symptoms fail to respond or show rapid progression despite supportive treatment in the hospital must be operated upon as soon as fluid balance is established. An impending gangrene or perforation should be suspected when the white count exceeds 20,000. Free perforation, carrying a mortality three times that of localized peritonitis, is relatively infrequent since the omentum usually walls off the affected area. For this reason, operation is more urgent in those patients with advanced signs and symptoms who have had previous abdominal surgery. An omentum bound down in another part of the peritoneal cavity offers no assistance in sealing off the gallbladder region.

A significant number of patients who are progressing satisfactorily under conservative treatment develop an exacerbation of their signs and symptoms. A recurrence of pain sufficient to require narcotics, an increasing temperature and white count, or a decreasing vital capacity, calls for prompt surgery.

Operation is delayed and conservative measures are justified in those patients showing continued regression of their disease process. Delay need not extend beyond 5 to 7 days, as it rarely adds to the safety of the patient and may be detrimental to the outcome. Operation can then be performed as a semi-elective procedure in an 'improved risk' patient. By taking advantage of the cleavage planes developed by the acute inflammatory process in the wall of the gallbladder, it is possible to do a complete cholecystectomy without excessive blood loss.

We are convinced that the mortality rate associated with acute cholecystitis will be improved if more patients are operated upon at any time during the day or night if, after fluid balance is established, they do not show evidence of continued improvement.

A second and even more common complication is common duct stone. Its diagnosis is usually considered from a history of jaundice, colic, spontaneous vomiting, chills and fever, particularly when associated with a past history of cholecystic disease.[5] All too frequently its presence is not suspected unless the patient is jaundiced at the time of operation. Although no individual sign or symptom constitutes an absolute indication of common duct stone, a careful evaluation of a number of these offers a satisfactory method. Jaundice and the finding of a dilated common duct at operation deserves special attention.

Analysis of our cases subjected to choledochostomy reveals some pertinent facts relating to the significance of jaundice.[2] Common duct stones have been recovered in nearly three out of every four patients who were jaundiced while in the hospital, but in only one out of every six patients who gave a past history of jaundice. The surprising fact is that a common duct stone was recovered in nearly every other patient who had never given a history of jaundice. More and more we are recognizing the facts that stones occur in the common duct without accompanying jaundice and that criteria additional to jaundice are necessary, if one is to avoid overlooking a calculus.

Additional findings at the time of operation may influence the surgeon to carry out exploration. We have found the size of the common duct to be of the greatest significance. Stones have been recovered in nearly one-half of all cases whose common duct was described as being either moderately or considerably enlarged. On the other hand, stones were recovered in only one case out of every ten whose duct was described as normal in size.

We have found it necessary to explore the common duct in 48 per cent of all cases submitted to cholecystectomy. One or more stones were recovered in almost half of the ducts ex-

plored, making an incidence of 21.8 per cent of all cases. It may well be that a fair percentage of the unsatisfactory results of gallbladder surgery in the past has been due to an overlooked calculus resulting from failure to explore the common duct in a sufficient number of patients.

Acute pancreatitis is a more common complication of gallbladder disease than is generally appreciated.[6] For this reason it is advisable to determine the serum amylase levels in all acute abdominal episodes suspected of originating in the biliary tract. Although an elevated serum amylase is diagnostic, these levels tend to fall to normal within 24 to 48 hours following the onset of the acute process. In those instances where pancreatitis is suspected but the patient is seen relatively late in the course of the disease, we have found it very helpful to study the amylase values on the peritoneal fluid obtained by simple lower midline peritoneal tap using an 18 gauge needle. The peritoneal fluid amylase is sufficiently elevated and persists long enough to be diagnostic for as long as six days following onset. As little as 2 cc. is sufficient for examination. These confirmatory tests are invaluable since a diagnosis of acute pancreatitis contraindicates early surgery.

Conservative management is similar to that for acute cholecystitis. In addition, ephedrine is of some value in controlling pancreatic secretions and has been used in conjunction with unilateral or bilateral splanchnic blocks for relief of pain.[8]

When the patient is fully recovered, a complete investigation of the biliary tract, including x-ray studies of the gallbladder, is accomplished. The gallbladder should be removed as indicated by these studies. The common bile duct is explored in all instances since pancreatitis should be considered a complication of common duct stone. This surgery should be performed during the same hospital admission to prevent possible recurrences. A week or ten days must be allowed to elapse following the acute attack of pancreatitis before attempting to visualize the gallbladder by cholecystogram, because non-visualization may result from the transitory pericholecystic edema and inflammation. Non-visualization or demonstration of gallstones give sufficient reason for surgical correction of the biliary pathology.

Associated gallbladder pathology was demonstrated and prophylactic surgery carried out in one of every two patients with acute pancreatitis, a total of 18 cases. These accounted for 7 per cent of the 231 patients operated for acute or chronic cholecystitis during a three year period. Gallstones were found in all those cases submitted to surgery. The common duct was explored in each instance, the history of acute pancreatitis being considered an indication for choledochotomy. Common duct stones were demonstrated in 4 (23.5 per cent) of these patients.

The finding of an occasional patient who complains of recurrent symptoms following cholecystectomy should not condemn the surgical management of gallbladder disease. Usually the trouble can be ascribed to one or more of four fundamental reasons: (1) Incorrect preoperative diagnosis. This group includes failure to recognize concomitant pathology as the prime cause of the patient's symptoms and, finally, the poor selection of patients for surgery. Cholecystectomy performed in borderline cases or where disease does not exist carries an endless chain of distressing digestive symptoms. Attention to the principles already outlined will help reduce this group to a minimum. (2) Incomplete surgery. This includes failure to completely remove the gallbladder or cystic duct or overlooking a common duct stone. (3) Complications resulting directly from the operation including injury to the duct system. (4) Residual non-operable disease of the biliary tract including 'biliary dyskinesia'.

The patient who has had a surgical drainage and removal of stones without subsequent removal of the gallbladder is very likely to have a recurrence of symptoms. Since the patient may not be well informed as to what was done at this primary surgery, it is important to obtain an accurate description of previous operation. A certain number of these patients have the mistaken impression that cholecystectomy was accomplished when actually the procedure was limited to cholecystostomy. We have been impressed with the number of patients denied the benefits of cholecystectomy in lieu of anticipated difficulties at the time of

reoperation. Complete removal of the gallbladder usually relieves the symptoms.

Although a remnant of the cystic duct overlooked at the time of cholecystectomy has been recognized as the cause of post cholecystectomy symptoms, it has received scant attention until recent years.[9,10] The mechanism of symptoms is probably the same as that for symptoms arising in a diseased gallbladder with the additional possibility of neuroma formation as suggested by Womack and Crider.[11] While cholecystography is without value in such instances, a plain x-ray of the gallbladder region may demonstrate calculi beneath the twelfth rib. We have encountered six patients during the past three years with biliary colic occurring many years after cholecystectomy. Symptoms were so severe and classical that exploration seemed unwarranted. At the time of operation a remnant of cystic duct measuring an inch or longer was found. Four of the retained ducts contained small stones or gravel. The high incidence in this and similar series suggests that a cystic duct remnant may be a frequent source of post-cholecystectomy symptoms. The fear of serious consequences of injury to the common duct probably explains the attitude of some surgeons towards its incomplete removal. In practice, the careful dissection and demonstration of the junction of the cystic and common duct, together with complete removal of the cystic duct, affords less chances of injury than mass ligation without anatomic dissection.

There is another group of patients in whom the symptomatology arises from an overlooked common duct stone. As pointed out previously, unless the common duct is opened in nearly 50 per cent of the cases and common duct stones recovered in 20 per cent or more of those cases, the best results cannot be expected.

Fortunately the number of accidents at the time of biliary surgery resulting in stricture formation are not too common, but all surgical clinics are confronted with a few of these patients every year. It is well for the surgeon to remember that there are more anomalies of the blood supply and ducts in the region of the gallbladder than in almost any other part of the body and great care must be exercised in technique in even the simplest of cases.

In many instances of re-exploration the duodenum is found firmly adherent to the gallbladder fossa. A previously performed GI series has usually failed to demonstrate any duodenal obstruction, but distortion is in evidence. Even though the surgeon should restore the anatomy to as near normal as possible by release of the adherent duodenum, it is difficult for us to believe that this condition would cause severe symptoms since it is a common occurrence following cholecystectomy. Until such time as this problem is settled, one should not only carefully reperitonealize the gallbladder fossa, but also place the omentum between the liver and duodenum in order to prevent its formation.

Once a physician has exhausted all forms of medication, and if after thorough investigation of the patient, including a flat plate for stones and a complete gastrointestinal, cardiac and renal survey, he is convinced that the patient retains pathology which is causing symptoms similar to those preceding removal of the gallbladder, exploration is advisable. In a large proportion of such thoroughly screened patients, the difficulty can be corrected.

There is a fourth group of patients in which residual disease of the biliary tract including cholangitis, hepatitis, or 'biliary dyskinesia', apparently occurs. It is unwise to accept such a diagnosis without the thorough study described. Early surgery with complete removal of all biliary pathology may decrease the number of such patients, but we know of no specific treatment, either medical or surgical, routinely efficient in alleviating symptoms once present.

Analysis of 42 patients recently subjected to secondary surgery of the biliary tract affords some interesting information. Sixteen of these patients had had a previous cholecystostomy, presumably for acute cholecystitis. The common duct was explored in each instance and stones were recovered in 14, an incidence of 33 per cent. Six, or fourteen per cent had retained cystic duct stumps. The overall mortality of secondary exploration was 2.4 per cent. Re-exploration is not contraindicated in those patients with recurrent colic where retained pathology is proved or suspected.

SUMMARY

1. Uniformly good results can be obtained from gallbladder surgery if the symptoms of those patients selected for operation arise from the gallbladder or its ducts and if the operation is thorough and complete.
2. Relief of symptoms may be expected in those patients with colic and demonstrable gallstones by cholecystogram. One should not accept a non-filling gallbladder on one occasion as pathological. The dye should be reinforced and the x-ray repeated. Final recommendations in all cases depends on a complete gastrointestinal survey.
3. Gallbladder disease may mimic, coexist with, or intensify heart disease. Cardiac disease does not contraindicate necessary gallbladder surgery.
4. The most common complications of gallbladder disease, acute cholecystitis and common duct stone, increase with each decade of life. Acute pancreatitis and carcinoma of the gallbladder are more prevalent in patients over 60 years of age.
5. Early cholecystectomy for 'silent gallstones' must be weighed carefully against the possible higher mortality rate from complications occurring in the older 'poor risk' patient.
6. Patients with acute cholecystitis require prompt hospitalization and individualized management. The optimum time for operation depends on the severity of the disease and the response to treatment.
7. Overlooked common duct stones can be expected unless the common duct is opened in nearly 50 per cent of the cases and stones recovered in 20 per cent or more of those cases.
8. Patients with typical colic after biliary surgery can often be relieved of their symptoms by reoperation and removal of residual pathology such as retained cystic duct stump and common duct stone.
9. The individual management of each patient together with the careful adherence to the details of operation insures satisfactory results.
10. The consistently good results of biliary surgery using present day methods should restore the confidence of both physician and patient in surgery for gallbladder disease.

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Psychoses of Later Life

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The better understanding of the serious emotional problems of later life was the basis for the study of a group of patients past the age of 45 who were discharged from the psychiatric unit in a general hospital (Loretto Hospital. Chicago, Illinois) during the two year period from July 1, 1947, to June 30, 1949. This group consisted of 245 individuals, representing 26 per cent of all patients hospitalized in the psychiatric division for this period. We have excluded 63 of this number because of a history of mental illness prior to the age of 45, or because the behavior disturbance was obviously of a gross toxi-organic nature. However, we retained this group for study a goodly number of patients reacting with a psychotic disturbance to quasi-organic brain disorder of the senile or arteriosclerotic type who were not demented. 182 patients remained with serious emotional illness appearing for the first time after 45 who were deemed suitable for so-called shock therapy on the basis of their psychiatric condition. All except nine of these patients received electro-convulsive treatment. Insulin therapy was used alone or in combination with electro-shock in seventeen cases.

This study was prompted by our desire to put to test several clinical impressions. We have long felt that the accepted classification of mental disorders does not fit the psychiatric syndromes which actually occur in many of these older patients. Often the diagnostic connotation encourages therapeutic inertia. Furthermore, although serious bodily disabilities are commonly encountered in this age group, it seems that their significance as a bar to shock therapy is dwindling toward a vanishing point in the light of our treatment experience. A third consideration in our study was to determine by adequate social service follow-up what short term private psychiatric care could promise in these cases.

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The diagnoses of the 182 patients studied were:

Involutional Depression	72	39.6%
"Presenile Depression"	37	20.3%
Psychoneurosis in an Involutional Setting (Tantamount to Psychosis)	22	12.1%
Paranoid State and Involutional Paranoid State	15	8.2%
Schizophrenic Reactions	12	6.6%
Manic-Depressive Psychoses	10	5.5%
Cerebral Arteriosclerosis with Psychosis	7	3.8%
Senile Psychoses	5	2.7%
Psychosis with Psychopathic Personality	1	0.5%
Hypertensive Encephalopathy with Depression	1	0.5%

On close inspection of the individual case records, in the group diagnosed as involutional depression, a considerable variation in the clinical picture appears. The predominant feature is the depressive reaction, occurring in the involutional period of life. But in this group of 72 cases we found 21 patients with marked psychoneurotic symptoms who had been neurotic persons through life, including a group of 6 with well-developed hysterical manifestations. This excludes 22 patients whose psychoneurotic symptoms so predominated over the depressive reaction that the diagnosis was made of psychoneurosis in an involutional setting. Another commonly encountered syndrome in this group was that of an associated paranoid reaction. This was so obtrusive in some that the diagnosis of paranoid state or involutional paranoid state instead of involutional depression was made. Aside from the 15 cases designated as paranoid states, there were 15 instances of "involutional depressions" with unmistakable paranoid features, even with systematized delusional content in some instances. Seven other patients with involutional depression were characterised by life-long subclinical cyclothymic reactions, two were markedly schizoid, and two had apparent memory defects.

Case 1. Illustrative of involutional depression is the case of A. K., who was treated for recurrence of depression within the limits of the period used for selection of these cases. He was 57 years old when admitted to Loretto Hospital for the first time on April 17, 1947. He had been well until about three months before, when the employees at his place of work underwent investigation because of thefts of company property. The patient began to fear that he would lose his job, although he was innocent of any wrong-doing. Gradually he worried more, began to have crying spells, became self-accusatory, slept poorly, lost weight and finally presented the clinical picture of a severe agitated depression with suicidal trends. He was first taken to a private sanitarium where he received several electroconvulsive treatments, then transferred to Loretto Hospital and given seven more treatments, with complete remission of depressive symptoms. During the course of treatment he developed severe pain, tenderness and some swelling deep in the right calf, presumably from rupture of the plantaris muscle. The cardiovascular system was apparently normal on the basis of medical history, physical examination and electrocardiography. The patient returned to work and was well except that a few weeks after discharge he began to complain of substernal pain aggravated by physical effort. His private physician did not consider this serious and advised no particular treatment.

On May 31, 1949 the patient was readmitted to Loretto Hospital with a recurrence of his former depressive state. He had received one electroshock treatment on an outpatient basis a few days previously, but his physical response to the treatment had been alarming, marked by prolonged apnea and deep cyanosis. An electrocardiogram revealed evidence of an old posterior myocardial infarction with changes in leads V_4, V_5 and V_6 indicating an extension of the process or a new process of anterolateral myocardial infarction.

Because of the severity of the depression, it was decided electroconvulsive therapy be continued. Atropine sulfate and caffeine sodio-benzoate were given subcutaneously prior to each treatment, and intravenous sodium amytal was used to control post-treatment excitement. After four inpatient electroshock treatments (five in all for this recurrence) the patient was discharged on June 6, 1949, free from depressive symptoms. He has remained mentally well since.

The label, "presenile depression," presents us with a diagnosis which again covers many dissimilar states. Such a classification is not given in any of the standard tables of nomenclature for psychiatric disorders. We adopted this designation to account for those patients showing a predominantly depressive reaction who were on the average ten years older than the patients in the involutional period. It has provided a convenient and adequate descriptive term for our use. True presenile dementia (Alzheimer's or Pick's) is not synonymous with this term, and cases so diagnosed were classified as organic brain disease and excluded from this group. The usual clinical features were depression with either apathy or agitation. These cases would have to be classified as late involutional melancholia in the standard nomenclature. But of our 37 patients in this category 24 had paranoid features, 4 were of a cyclothymic temperament, four neurotic persons, and one was a psychopath. Nine of the patients showed seeming memory defects, indeed appeared demented in varying degrees. Six of these were followed. Memory returned to normal in four and remained so. One patient had complained of a loss of the senses of smell and taste, but these returned following treatment.

Reports of cases classified as "presenile depression" follow:

Case 2. P. D., a 62 year old white male, experienced a depressive reaction one and one-half years ago which was treated successfully with electroshock. He remained well until five weeks before admission to the hospital. At that time he became worried over a new business venture, feared that he had taken on too much responsibility, had disgraced himself, and that there was no hope for him. He was very apathetic, could not work, and considered suicide. There were no physical contraindications to electroconvulsive therapy. There was a noticeable elevation of mood after the fifth treatment and following the tenth treatment an excellent remission was achieved. The patient has remained well for the past 28 months.

Case 3. A. M. a 60 year old white woman, experienced a severe depression with apathy for several months following the death of her daughter. She had many somatic delusions of a nihilistic nature and was extremely self-accusatory. Three months previously she had attempted suicide by drinking kerosene. Memory, retention, judgment and calculation were found to be poor, and the patient was poorly oriented for time and fairly oriented for place. There appeared to be no physical contra-indication to electro-shock treatment. After each treatment the patient became more and more confused until the fifth, when the confusion began to subside, and the patient became cheerful, cooperative, and interested in her surroundings and personal care. After the seventh and last treatment the patient was still somewhat confused; this soon wore off and the patient has remained well for the past 28 months.

There were 12 patients who manifested a fairly typical schizophrenic reaction for the first time after the age of 45; in five the psychosis

was of the paranoid type. Six of the patients had always been schizoid, but the other five apparently had been well adjusted. Moreover, seven patients showed a paranoid reaction so severe that it was diagnosed as "paranoid state," with onset subsequent to the age of 45.

This breakdown of the diagnoses shows that the term involutional depression and "presenile depression," while adequate in many instances, does embrace a number of dissimilar states. Our diagnostic table furthermore indicates that an appreciable number of schizophrenic and cyclothymic psychoses may have their inception 15 to 30 years beyond the generally recognized age of onset.

Regardless of our classification in the patients over 60 years of age it seems fairly certain that cerebral arteriosclerosis and other degenerative brain changes incident to the aging process were present. The term quasi-organic seems to us to describe eminently this group of psychiatric reactions and in our treatment, experience carries the connotation of reversibility and improvement. Many physicians have come to regard psychoses occurring in older people as evidence of an abject, irreversible degenerative change not amenable to treatment and necessitating relegation of such patients to custodial care. We have included in the concept of quasi-organic reaction certain cases diagnosed as cerebral arteriosclerosis with psychosis or senile psychosis in which the behavior disturbance was not grounded in dementia.

The following case in our series represents a quasi-organic psychosis which was classified as psychosis with cerebral arteriosclerosis:

Case 4. S. C., a 62 year old white female presented symptoms of a depressive reaction, together with some disorders of memory for recent events and paranoid delusions. Fifteen years previously at the climacterium she had a severe emotional reaction, evidently of a depressive nature, which subsided without treatment. Physical examination revealed blood presse of 220/110, left ventricular hypertrophy, and grade 2 hypertensive retinopathy. There was otosclerotic deafness necessitating use of a hearing aid. Degenerative arthritis of the right shoulder and ankylosing spondylitis of the cervical and thoracic spine were present. Spinal fluid examinations revealed normal findings. There was a marked improvement in the patient's mood after the third electro-shock treatment, but she complained of severe pain in the right humerus. X-rays showed recent fracture of the head of the right humerus, whereupon electro-convulsive therapy was discontinued. The fracture healed without incident. The patient's emotional condition was good at the time of discharge and she has remained mentally well for the past 18 months.

It has been shown adequately by other investigators that the contra-indications to electro-shock are not numerous. Age per se is not a contraindication. The oldest patient in our series was 78 years old. We wish to re-affirm the views of previous investigators[1, 2, 3] and to point out that in our series there were many patients with serious physical abnormalities who were successfully treated. We have treated patients with recent and chronic myocardial infarction, bundle branch block, auricular fibrillation, and valvular heart diseases. 134 or 71% of our patients had a significantly elevated blood pressure. There were only three not suitable for treatment; two due to recent fractures, and one because of a severe cardiac insufficiency. There were no deaths due to treatment, a situation in which good fortune undoubtedly played a part. All of our serious complications were fractures. We had one fractured humerus and one incomplete fracture of the scapula. There were several proved compression fractures of the spine, and undoubtedly compression fractures of the spine which were not detected; these were not considered serious disabilities and were not a factor in altering the course of treatment. Curare was not used in conjunction with electro-shock because we felt that it constitutes a greater hazard than the occassional fractures which it might prevent.

The danger of suicide in this age group was an urgent reason for vigorous therapeutic intervention. One patient in our series was successful in a suicidal attempt; 60 patients were considered suicidal risks of varying severity.

Our social service department gave us a report on the status of these patients varying from 6 to 30 months after discharge in 148 or 81% of the series. The results are shown in the following table.

RESULTS OF TREATMENT IN 148 CASES 6 TO 30 MONTHS AFTER DISCHARGE FROM HOSPITAL

1. No recurrence of symptoms....66 (44.6%)
2. No improvement or rapid relapse unimproved by subsequent treatment 49 (33.2%)

This group included patients who

(a) died without improvement ..2 or 1.4%

(b) were not treated altho physically suitable for treatment 5 or 6.8%

(c) were not treated because of physical contraindication 3 or 2.0%

3. Recurrence but improved after one or more courses of electro-shock treatment 26 (17.6%)

4. Mild recurrences, insufficient to warrant further electro-shock treatment or hospital care 7 (4.7%)

Total substantially improved 99 (66.9%)

(Approximately 2/3)

The best thereapeutic results were obtained in the depressive states in which there was no admixture of schizophrenic or neurotic features. However, improvement was shown in all categories of mental illness in our group. Futhermore, we separately appraised the results of treatment of the 20 patients in the group beyond the age of 65, where it would seem that little benefit could be expected. Fifteen of these patients were improved on discharge, five were not improved. Fifteen of this group were followed adequately: six had relapsed, there were fairly well, and six had had no recurrence of symptoms. The results in our small elderly group approximate those reported by Clow[4], who revealed an unusually optimistic outlook for a series of 365 patients admitted to a mental hospital after the age of 60. Whereas the duration of hospitalization for the patients in his series was measured in months (up to eight years), in our series the length of stay in the hospital was a matter of weeks. Only 52 patients in Clow's series were treated by means of convulsive therapy.

Private psychiatric care is costly, yet in this age group, it is less expensive than in younger patients. These illnesses require fewer treatments and hence a shorter period of hospital care than the schizophrenic reactions, which in the younger patients most frequently demand hospitalization. These are our figures of age, hospital stay and number of treatments by electro-shock in the two most numerous classifications:

Involutional Depressions	Presenile Depressions
Ages — 45-65 (range)	Ages — 57-78 (range)
52.4 (median)	61.3 (median)
52.7 (average)	62.9 (average)
Hospital Days —	Hospital Days —
5-61 (range)	1-64 (range)
17.5 (median)	21.2 (median)
21.7 (average)	25.5 (average)
Treatments — (EST)	Treatments — (EST)
1-25 (range)	3-31 (range)
8.4 (median)	7.8 (median)
8.8 (average)	9.4 (average)

This study emphasizes the feasibility and economic advantages of electro-convulsive therapy for patients in later life who present mental illness of a non-dementing or quasi-organic nature. While our results both with respect to emotional improvement and infrequency of serious complications may in this particular survey be extremely fortunate, they indicate that substantial gain may be expected from vigorous physical methods of treatment. The present standard classification of psychotic reactions in aging individuals is neither sufficiently descriptive nor etiologically clear, and in the quasi-organic reactions often implies an unjustifiably ominous prognosis derived from experience in the era before convulsive therapy was employed.

We are impressed by our experiences that individuals who have maintained their emotional poise in the face of the varying rigors and vicissitudes encountered during the period of 45 or 50 years of living, possess more than a little in the way of personality resilience; and that should they exhibit a severe behavior disturbance in later life not secondary to extensive destructive brain change accompanied by serious dementia, the outlook for recovery following shock therapy is decidedly hopeful.

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Painful Shoulder Due to Calcareous Tendonitis

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Painful shoulder due to calcareous tendonitis is specifically labeled under a loose group of terms such as bursitis, tendonitis, subacromial bursitis, humeroscapular bursitis and a host of similar names. It is a common complaint, occurring at any time in adult life. It appears to have little relation to age, sex or occupation. Permanent relief from pain is seldom obtained without resorting to some type of surgical procedure or irradiation therapy. In this summary the results of a series of cases treated only with x-radiation are recorded.

The shoulder joint is enclosed by a cuff composed of the tendons of the supraspinatus, infraspinatus, teres minor and subscapularis muscles. These four tendons are the short rotators of the shoulder. They are broad, flat and about one inch in length and are closely incorporated with the capsule and subacromial bursa. The floor of the bursa covers the upper and outer 2 cm. of the greater tuberosity of the humerus, the bicipital groove and the cuff.

Codman[1] was one of the first to point out that calcified deposits may form in one of the tendons and remain for years. Or they may gradually work through to or enlarge enough to reach the base of the bursa where they produce a mound-like swelling resembling a small boil. Up to this time there may have been no symptoms. Then some unusual movement may cause enough tension in the tendon to force some calcified particles into the bursa and localized inflammation begins, with moderate to severe pain.

The complete pathologic findings have been stressed again and again by Codman, Key[2], Hodges, Phemister and Brunschwig[3] and many others. The picture can be summarized briefly by stating that the bursitis is always secondary to the tendonitis and the production of calcified deposits. It should be emphasized that only when the tendon deposit is large enough or causes inflammation about it great enough to interfere with the function of the bursa do symptoms of bursitis appear.

Clinical signs are well recognized and do not require discussion except to point out that the area of greatest tenderness is usually just distal to the acromion process. Pain may be very severe and may radiate down the arm. Abduction and internal rotation are difficult or impossible.

For obvious reasons roentgenograms should be made in every case. In the last 120 consecutive patients seen with this complaint in the outpatient department, 68 per cent revealed calcific deposits near the head of the humerus and the majority appeared to be located in the supraspinatus tendon.

This report deals only with those cases revealing definite areas of calcification in one or more of the tendons of the shoulder cuff.

Each year more patients are seen and treated for this complaint. Among the many hundreds of such cases in our files, I chose as a cross-section all those patients treated from January 1, 1948 to April 1, 1949, the total number being 186. The right shoulder was affected in 114, and in the group were 60 females. The youngest patient was 24 and the oldest 78 years of age.

The statistics for this report were compiled from a questionnaire sent to the 186 patients. Replies were received from 117, or 62 per cent of the patients, with the following information:

59 patients, or 50 per cent, reported complete relief

42 patients, or 36.2 per cent, reported partial relief

12 patients, or 13.8 per cent, reported no relief

These figures do not show cause for enthusiasm and a 50 per cent symptom-free group after treatment is smaller than one would anticipate after glancing over the current literature. No attempt was made to divide the group into subgroups, classifying them as acute, subacute and chronic. This has been done by many writers.

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All who have had experience in this field are aware that the acute case with symptoms of short duration shows a more prompt response to irradiation therapy. Chronic cases of long duration rarely report complete freedom from pain after treatment. However, since more than 85 per cent of the patients who responded to the inquiry stated that they received complete or partial relief, the author believes there is adequate justification for this conservative type of treatment.

The various methods of applying roentgen therapy in this condition differ principally in tension. Some therapists prefer the 120 to 140 kilovolt range; others use 180 to 200 kilovolts. Some use two fields, others three, but the total dosage in r units is not widely different.

The technic used in this group was as follows: 200 kv.. 18 ma., 50 cm. distance, Thoreaus filter, h.v.l. 2.0 mm. Cu. One anterior and one posterior field were used, each measuring 10 x 10 cm.; 200 r (air) was given over one field at each visit, the fields being treated alternately. Treatments were given every second or third day for a total of four to six.

If the condition is very acute and of recent origin, Jenkinson's method[4] is followed and treatments are given on the 1st, 2nd, 4th, 7th, 12th and 14th days.

In those cases of longstanding in whom the relief is minimal after one month, occasionally two more treatments are given.

The total dose in air over each field, therefore, varies from 400 to 800 r. No post-radiation skin changes have been observed.

During the period in which treatments are given and for at least one week thereafter the patient is advised to carry the arm in a sling. As soon as the pain diminishes, however, instructions are given to practice internal and external rotation and abduction several times each day.

For patients who show little or no improvement during the time they are under treatment, it has been recommended[5] that the nerve roots of the third, fourth and fifth cervical nerves be treated because their fibers supply the skin of the neck and shoulders. In the experience of the writer this is of no benefit. If therapy directed to the area of calcific deposit does not relieve the patient, further treatment of adjacent fields will not do so. We are concerned here with the problem of inflammation about the shoulder joint. The resolution of that inflammation by roentgen rays usually occurs, although the mechanism of this action is not clearly understood. If it does not occur, the therapist should recog-



Figure 1. Case 41 of this series. The left shoulder of a 40-year old female. Duration of symptoms two weeks. Film made few days prior to beginning treatments. Calcareous deposit of moderate density.



Figure 2. Case 41 of this series. Same shoulder three months later. Calcification no longer visible. Patient stated pain and disability had ceased one month after treatment.

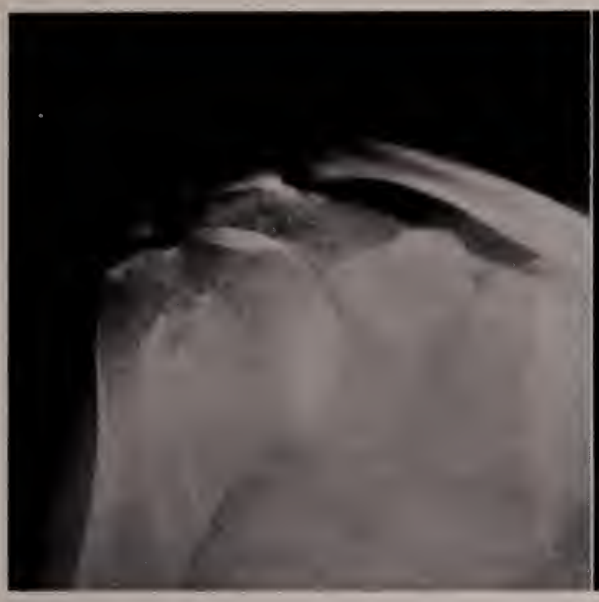


Figure 3. Case 108 of this series. The right shoulder of a 48-year old male. Pain in shoulder for one month prior to examination and treatment. Calcified deposit in supraspinatus tendon.



Figure 4. Case 108 of this series. Same shoulder six months after treatment. No calcification visible. Pain diminished during treatments but did not disappear entirely for three weeks.

nize the fact and further effort tends only to discredit the whole procedure.

Whenever possible roentgenograms are made from one to six months after treatment to check the results. This is not a routine practice in our hospital but it has been done in many instances. On the basis of such findings plus the clinical observations made at follow-up examinations, it is clear that complete freedom of movement with no pain may be obtained without the disappearance of the calcareous mass, although both the density and size of the shadow in the films is usually decreased in those patients who are for the present free from pain.

Unless the deposit is entirely absorbed after the course of treatment, recurrence of pain at some later date is probable. This observation has been made so often that it is felt the degree of permanent relief is directly proportional to the amount of calcific absorption that occurs. When the follow-up films show that the previously visible deposit has disappeared only then can one be confident that the patient's disability in this respect is over.

30 North Michigan Avenue

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What Makes A Good Internist?

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Clinicol Professor of Medicine

SEMINAR
of the
UNIVERSITY OF ILLINOIS
DEPARTMENT OF MEDICINE
AND
COOPERATING DEPARTMENTS
Edited by:
Max Samter, M.D.
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Dr. Sloan: The definition of the word internist is unsatisfactory. Still more difficult is the definition of an "internist". Patients and the public confuse internist with interne and many a distinguished specialist in internal medicine has been chagrined by being taken for the senior interne. An internist has been defined by wise crackers as a general practitioner who has given up obstetrics. Such gentle ribbing of course hits all classes of specialists. I much prefer the term diagnostician since our primary purpose in the scheme of today is to establish the diagnosis in a goodly percentage of patients seen in busy clinics or hospitals or in practice and to direct the therapy in those which can be handled without recourse to surgery.

No one has stated the case for internal medicine better than Sir William Osler. I would encourage the young men of this department to carefully delve into the life of this distinguished practitioner whose textbook was the bible of medical diagnosis to those who can count their medical sojourn from 30-50 yrs. Osler cautioned his students not to regard internal medicine as a limited specialty to the abrogation of all other medical pursuit or study. He was a realist both as regards the time necessary and the effort required to perfect one in the training of a diagnostician in internal medicine. He pictured to his students the dry bread period of practice, the bread and butter period and the cakes and ale period. He warned his students not to depend on medical practice alone to keep up with the current but to attend instruction and classes and to work in teaching institutions but above all to keep on reading. He scorned publicity and taught the aspiring youngsters to avoid it where possible. "Do not toy with the Delilah of the Press", he warned, for "sooner or later sure to play the harlot", — she "has left many a man shorn of his strength". Today we should cooperate with the Press in an intelligent fashion. He endorsed travel. In fact, it seems that Sir William was always on the go and from each little journey brought back a nugget of educational wealth to share with others. The young buck must "put his emotions on ice" if he were to succeed. Today, our aspirants do not put their emotions on ice but find a partner in effort. It is probably better thus. In order to keep one's mind receptive, plastic and impressionable this great physician bade his colleagues associate with men between the ages of twenty-five and forty. If one did attend classes, work in the clinics, study, travel, listen and absorb, Osler felt that at forty-five the diagnostician would have a first-class reputation in the profession, have a large circle of friends and students, have a little capital in the bank but a very large accumulation of interest bearing funds in his brain pan.

What made Osler the great man that he was? Early in his youth he came under the influence of Father Johnson, the rector of the parish in the town of Dundas where Osler was born. This gentle parish padre was artist, wood carver, microscopist, nature lover and naturalist. He taught Osler to observe, study, restudy, use his fingers, his eyes, his nose, his ears — all his senses and to record what he saw. So was born to bedside medicine the familiar inspection, palpation, auscultation, and percussion — still of utmost importance in good diagnosis. For a time during his adolescence he was seized with the idea of going into the Church to study for Holy Orders. Apparently he was more in-

fluenced by the picture of the nature lover than the priest in Father Johnson. Hero worship seemed natural and stimulating through Osler's life. He looked upon Palmer Howard who headed up the first department of medicine at the new school of medicine at the University of Iowa as "an ideal teacher because a student ever alert to the new problems — an indomitable energy enabled him in the midst of an exacting practice to maintain an ardent enthusiasm, still to keep bright the fires which he had lighted in his youth".

He said in one of his many talks, "I would insist that every assistant connected with the clinic taught, but for the majority daily contact with students and a little of the routine of teaching keeps us in touch with the common clay and are the best preservatives against that staleness so apt to come as a blight upon the pure researcher."

Osler felt that the function of a university was to learn and to advance learning. He leaned to the Greek concept of the pursuit of knowledge for its own sake. His opinions were shaped not alone by his background of keen observation but by contacts with men, by experience and by constant regard for the past and daily study of newer concepts and ideas. For myself, I believe that the translation by scholarly Charles Henderson of the first motto of the University of Chicago sums up Osler's whole idea of education and though dimmed by recent changes may still light up our medical and educational objective — "Crescat scientia — vita excolatur" — 'let knowledge grow from more to more and life be enriched'. Our ideas of today in the manufacture of a good internist dovetail right into this. Know your objective — doggedly pursue the path toward such an end — at all times relentlessly sifting facts and fancies — conscious of the necessity of intelligent interpretation. At this point I would say a word about diagnosis by intuition. As students we are amazed at the ability of some to arrive at a diagnosis with alarming facility and immeasurable speed. I will never forget the instant recognition by one of our leading internists of a patient with a ruptured ectopic pregnancy — one look and it was over, although several of us had been confused for two or three days. And another of the instant diagnosis and localization of a brain tumor on the subtle changes in motor power and the gait of the patient or another of a forme fruste perforation on a single palpation of the abdomen. This so-called pot shot diagnosis is often spectacular, but never entirely reliable. For most of us meticulous examination of the patient should still remain our ambition and objective. It is surprising how much can be lost, or unrecognized by the omission of just one of our major endeavors in physical examination. Just as sure as we do forget or neglect one of these little jobs just as sure will it bob up to haunt us later.

Of increasing importance is the extent to which a diagnostician or internist should engage in research. I would believe that all along the way he should be engaged in research, although I also feel that the word research has been belied, badgered, used as cover, escape, excuse, and prostituted beyond recognition. Investigation is a better word. Research is an individual problem. Some of us never would make good research workers and found it out early, though we have tried to keep attuned to sensible progress and to engage along the way in prospering progress and advancing knowledge. Some men are brilliant clinical teachers and poor researchers, and many researchers are atrocious clinical teachers. Each one brings to you something of discerning knowledge which makes for the complete picture.

A good medical diagnostician must have an open mind; he must be willing and able to weigh the ideas of the congregations of his peers, colleagues and superiors by attending meetings, reading books, and current periodicals. He should also gain experience and knowledge in allied fields not alone of other medical specialties but also of contemporary scientific endeavor. At the present moment cytochemistry and radiation physics are becoming more and more important to daily work.

Finally, as one travels the road of medical practice he should extend his interests to fields entirely separate from bedside medicine. Recently amongst a small gathering of leading internists was a collector of rare books, another was an accomplished musician, another a part time farmer, another a connoisseur of rare objects of metal, another a pianist of standing, another a recognized Latin and Greek student.

One of the most helpful ingredients to the production of a successful internist is an understanding wife.

The *rennaisance* of medicine in this country began about 1898 when the four horsemen of Hopkins — Osler, Welch, Halsted and Kelly — brought students to the medical and surgical wards and introduced the broad concept of bedside teaching. Then in 1905 the Council on Medical Education was founded under the chairmanship of Arthur Dean Bevan from our splendid institution across the street. (Rush) The *revolution* in medicine came with the publication of the Flexner report on the status of the medical schools of this country. Many schools were closed to the good of all. In 1914 full time teachers were added at Hopkins and the controversy was on. I cannot answer for you the question of whether we should have all full time teachers in our medical schools. I can only state that personally I believe that the student can learn much from a well trained, alert clinician engaged in private practice. I trust that the contact will never be broken but I also recognize that the medical departments of our present schools can use the services of a full time teaching group. Perhaps it might be a good idea to farm out the full time teachers for three months of the year into daily contact with patients in their homes. Perhaps it might not be a poor suggestion to take in good clinicians engaged in private practice for three months at full salary to expose the students to the vagaries of realists. As Cushing suggested many years ago, it might be worth while to have the head of the medical department for a time make rounds on the surgical service and vice versa.

The program of standardization of hospitals spark plugged by Dr. John Bowman who had lately resigned as President of the University of Iowa and engineered by Franklin Martin under grants from one of our leading foundations and carried along for years by Malcolm Mac Eachern and his band of helpers which got under way in 1920 did more to elevate the standards of hospital practice than anything before or since.

Within your own life span the Boards of Certification have brought to bear an influence of stupendous merit in stimulating young men to shoot for a high professional objective. Here and there the standing of the boards has been overemphasized and experience has been cast headlong and certification glamorized beyond recognition but all in all the boards have added catalysis and symbiosis to a stagnating pool.

The American College of Physicians has undertaken the formal and formidable task of setting up qualifications in internal medicine for its associates and fellows in this wilderness of specialization. By the way, specialism is nothing new. It existed way back in Galen's time when specialists were all over the map.

I have always had profound respect for the alert, well trained, competent and discerning general practitioner. I know of no scheme of practice which will divorce him from the pack of necessary artisans of medicine. But in the rapidly growing and complex scheme of work one must come to the time when he recognizes that he cannot be all in all all of the time for all of those who wish his services. Specialism is inevitable.

An associate of the American College of Physicians who may be approved for fellowship after a minimum of three, and a maximum of five years must:

1. have a degree from a medical school acceptable to the Board of Regents of the College;
2. be a member in good standing of his local, city, state, and national (or as the case may be, provincial or territorial) medical association or in a full time hospital, teaching or research position;
3. confine himself to internal medicine or an allied specialty;
4. have completed basic training and be eligible for the American Board of Internal Medicine or the board in his specific field;
5. be established in a permanent location for two years and have the personal approval of fellows and masters in his local territory as to character, ethics and medical activities.

These are good criteria. They are only the framework for what is necessary to the stature of a good internist. A carefully planned basic training is very important. A continuing alert reception by formal contacts with moving medicine are equally important. Clinical experience tempered with courageous honesty should be brought into the forefront of our professional thought if you and I are to continue to give our best effort and if we are to give to our students,

and our colleagues a measure of our accepted professional scholarship.

And so let me summarize our thought for today. The young man of today who would be a good diagnostician in the medical field would do well to read the life of Sir William Osler. He should establish his objective early — home, family, children, continued study, clinical practice, daily contract with moving medicine, and pursue that objective cognizant of progress in related fields, accepting the ideas of others after critical evaluation, meticulous in his examinations, and appreciative of how much those about him may be quietly doing to aid this progress. In short, crescat scientia — vita excolatur.

Dr. Robert M. Kark, Professor of Medicine, University of Illinois: I note that you stress the meticulous examination and training of critical observation thru bedside experience. How is one to train the student to sharpen his power of observation?

Dr. Sloan: By precept. For this sort of teaching, the instructor must have had much experience to be effective. By quizzing the student in thoughtful fashion on those points which he has passed up in his observation of the patient at hand. Some students will never learn to observe critically. Under constant stimulation most will.

Dr. Robert W. Keeton, Professor of Medicine, University of Illinois: One of our difficulties is the lack of imagination in the student.

Dr. Sloan: Unfortunately this is becoming more and more evident. It would seem to be a part of the total breakdown of effort. The more the presence of directed imagination the better will be the doctor.

Dr. Herman Levy, Assistant Professor of Medicine, University of Illinois: I feel one lack in our present teaching system is the emphasis on major medicine rather than minor medicine. The student is taught continually to look for the serious and far advanced disease.

Dr. Sloan: This is true but it should be overcome in part by teaching in the out patient clinic. The bulk of patients seen by an internist or diagnostician have minor difficulties which however may be major to the patient. A good internist should try at least to recognize the origin of such problems and treat them for what they are. He should be so schooled that he will be able to manage most but he also must be able to channel the remainder into contact with appropriate therapists.

THE RICE DIET

A team of physicians working at Columbia University College of Physicians and Surgeons in New York treated 50 hospitalized patients for an average of 10½ weeks, giving them the strict rice diet as prescribed by Dr. Walter Kempner of Duke University. The diet consisted of about a pound of rice daily plus white sugar or dextrose, and fruit or fruit juice.

Reporting in the American Journal of Medicine the physicians agreed that if this diet is followed with sufficient attention to detail, a number of patients with severe essential hypertension will experience a reduction in pressure. This drop in pressure appears to be due mainly to the very low content of sodium in the rice diet.

The writers emphasized however that most of the patients on this strict diet returned to their hypertensive condition as soon as the diet was stopped. The doctors warned also, that the rice diet is not a practical method of sustained treatment. The trouble is that the food is so unpalatable and monotonous that the patient cannot stand it long enough to obtain the desired effect. *Excerpt: GP, April,* 1951.

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

A Situs Inversus Totalis and Perforated Peptic Ulcer

S. Fogelson, M.D.; J. Kerrigan, M.D.; and R. Swerdlow, M.D.
Chicago

The combination of perforated peptic ulcer and situs inversus totalis is infrequent.

E. L., a 58 year old white male, entered the Cook County Hospital at 6 a.m. on March 16, 1951, and was admitted to the ward as an emergency. He stated that he had been in good health all his life, with the exception of "arthritis" seven year previously, and a quinsy sore throat many years ago.

Six day prior to admission he developed the symptoms suggestive of an upper respiratory infection, along with mild anorexia, and pain in the left epigastric area which he described as sharp but intermittent and transitory. He was mildly constipated and was forced to resort to a laxative. He had no previous symptoms suggestive of ulcer.

At 3 a.m., on the day of admission, he arrived home from work, was hungry, had a cup of coffee to drink, and went to bed completely asymptomatic. One-half hour later he awakened with severe pain that began on the left side of the abdomen but became generalized within a few minutes. It radiated to the left shoulder but not to the right shoulder, groin, or back. He stated that this was the most severe pain that he had ever experienced. A local physician was called and administered morphine intravenously and sent patient to the hospital.

Physical examination at the time of admission revealed a blood pressure of 135/80; Respirations 24 per minute; pulse 80 per minute. A five minute rectal temperature was 99. He was in acute distress.

The positive physical finding was limited to the thorax and abdomen. The cardiac apex was palpated in the mid-clavicular line on the right, and the heart tones were heard best in the right mid-thorax.

The abdomen was board-like in its rigidity. The liver dullness extended into the left upper quadrant. On the right, there was a hyperresonant area similar to Traubes semilunar space. No other organs or masses were palpable. There were no peristaltic sounds.

The white blood count was 11,900; Hgb. 85%; sedimentation rate 11 mm. in one hour; and the hematocrit was 43%. The serum and



Figure 1. The thorax is normal except for the dextro cardia. The identification number is on the patient's right. A tube is noted in the esophagus.

urinary amylase were 8 units. The N.P.N. was 27, and a liver profile normal. The electrocardiogram was compatible with a dextrocardia as did a roentgenogram of the chest. A scout film of the abdomen revealed the liver shadow to be in the left upper quadrant, and the stomach bubble was in the right upper quadrant. There was no evidence of pneumo-peritoneum; the gas pattern was not pathognomonic.

Six hours after admission, the patient was anesthetized with cyclorpropane-ether endotracheal anesthesia and a high left para rectus incision was made. The situs inversus was verified and the appendix, gallbladder, liver, duodenum were on the left side.

A free perforation of a duodenal ulcer was found. The opening was ½ inch long and ¼ inch in width. It was situated in the superior aspect of the duodenal curve. The perforation was closed with a free omental graft held by three sutures. The abdomen was closed in three layers, catgut to the peritoneum, wire to the fascia, and silk to the skin, after the lateral gutters and sub-phrenic spaces were aspirated clean. The patient was placed on penicillin and streptomycin, and the postoperative course proceeded in an uneventful convalescence. On the tenth day the sutures were removed. The patient was discharged on medical management and is to be followed in our clinic.

It is interesting to note that there is no similar case reported in the American literature during the past ten years. It is estimated that situs inversus totalis occurs in one out of every 50,000 births.



Figure 2. Scout film of the abdomen. The crossed pins are on the patient's right. The liver shadow is on the left. The curve of the Levine tube indicates that the stomach is on the right and the duodenum on the left. The knotted portion of the tube is laying on the anterior abdomenal wall.

HOUSE OF DELEGATES



SECOND SESSION MAY 24, 1951

The second session of the House of Delegates was called to order by the President, Dr. Harry M. Hedge, on Thursday, May 24, 1951, at 9:15 A.M.

THE PRESIDENT: The first order of business is the report of the Credentials Committee by Dr. Harlan English.

DR. HARLAN ENGLISH, Danville: The Credentials Committee has certified 151 delegates, 5 officers and 17 members of the Council, a total of 173. I move that they constitute the active voting strength of this body. (Motion seconded by Dr. Fred Muller, Chicago, and carried).

THE PRESIDENT: The next order of business is the roll call by the Secretary.

DR. MATHER PFEIFFENBERGER, Alton: I move that we accept the report of the Credentials Committee as the voting strength of the House. (Motion seconded by Dr. J. J. Moore, Chicago, and carried).

THE PRESIDENT: The next order of business is the reading and approval of the minutes of the previous session. This will be dispensed with unless there is objection from the floor of the House. The minutes will be published in the July issue of the Journal.

We will now have the announcements of Awards to Scientific Exhibitors by Dr. Coye C. Mason, Chairman and Director of Scientific Exhibits.

DR. MASON: There are two groups of awards, one for original work and the other for exhibits of educational value. In each group gold, silver and bronze medals are given. These are the awards that were given this year:

Original Work

Gold Medal: "Pathogenesis of Sickle Cell Anemia and Other Hereditary Hemolytic Syndromes". Karl Singer and Amoz I. Chernoff, Chicago. Department of Hematologic Research, Medical Research Institute, Michael Reese Hospital.

Silver Medal: "Rapid Freezing of the Bladder: An Experimental and Clinical Study". James H. McDonald, C. Bruce Taylor, Norris J. Heckel, and W. A. Rosso, Chicago. Presbyterian Hospital in affiliation with the University of Illinois College of Medicine.

Bronze Medals: "Arteriography in Peripheral Vascular Disease". D. Movitz, E. G. Warnick, and Leo M. Zimmerman, Chicago. Cook County Hospital and Chicago Medical School.

"Allergy and Alcoholism". Theron G. Randolph and Joseph Interlandi, Chicago.

"Cardiac Kitchen". Margaret H. Austin, Women's and Children's Hospital, Chicago.

Educational Value

Gold Medal: "Congenital Heart in Pediatrics. Based on Study of 700 Cases". Benjamin M. Gasul, Egbert H. Fell, William P. Mavrellis, Maurice Lev, Oldrich Prec, and Raul Casas, Chicago. Hektoen Institute of Medical Research, Children's Division of Cook County Hospital, University of Illinois College of Medicine, and Presbyterian Hospital.

Silver Medal: "Pregnancy in Bicornuate Uterus". Frederick H. Falls and Charlotte S. Holt, Chicago. University of Illinois, College of Medicine, and Illinois State Department of Public Health.

Bronze Medals: "Human Brain Preparations Mounted in Plastics". Otto F. Kampmeier and Mr. Emil W. Hospodar, Chicago. University of Illinois College of Medicine, Department of Anatomy.

"Tuberculosis in Children". M. R. Lichtenstein and Samson Entin, Chicago. Municipal Tuberculosis Sanitorium of Chicago.

"Correlation of Unipolar Electrocardiography". George A. Hellmuth, Allen H. Weiss and Arthur G. Mulder, Chicago. Stritch School of Medicine of Loyola University.

I think you would be interested to know that we had more applications for the space than we could accommodate. We were only able to take 37 on account of the space. I would like to thank my Committee consisting of Hugh A. Flack, Arkell M. Vaughn, Lawrence W. Peterson, Dwight E. Clark, and Leo M. Zimmerman.

We were very fortunate in having many original exhibits. This year there are some 12 going to the meeting of the American Medical Association at Atlantic City, and this is only because the exhibitors were able to present exhibits made up of original work.

THE PRESIDENT: I think this is a tremendously fine report. I feel that the House should give Dr. Coye Mason a rising vote of appreciation. Again we thank you Dr. Mason.

(Rising vote of thanks)

We come to the next point on the agenda, the election of officers for the coming year. I will receive nominations as they come in from the floor or from anyone authorized to make a report for his caucus.

DR. RICHARD GREENING, Chicago: In order to facilitate matters I move you, Mr. President, that Dr. Walter Bornemeier, Secretary of the Chicago Medical Society, make the nominations of the official caucus of the Chicago delegation for officers for which we voted. (Motion seconded by Dr. Warren Furey, Chicago, and carried).

DR. WALTER BORNEMEIER, Chicago: The Chicago caucus would like to place in nomination for President-Elect the name of Dr. Leo P. A. Sweeney.

DR. P. R. BLODGETT, Chicago Heights: I move that the nominations be closed and the Secretary be empowered to cast the affirmative ballot for the election of Dr. Leo P. A. Sweeney as President-Elect. (Motion seconded by Dr. Arkell M. Vaughn, Chicago, and carried). (The ballot was cast and the President declared Dr. Sweeney elected).

THE PRESIDENT: Nominations are in order for First Vice-President.

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. Fred H. Muller for First Vice-President. (Seconded by Dr. E. S. Hamilton, Kankakee).

DR. G. HENRY MUNDT, Chicago: I move the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Fred H. Muller as First Vice-President. (Motion seconded by Dr. Warren Furey, Chicago and carried). (The ballot was cast and the President declared Dr. Muller elected).

THE PRESIDENT: Nominations are in order for Second Vice-President.

DR. E. H. WELD, Rockford: I would like to nominate Dr. J. Howard Maloney of Rockford for Second Vice-President. (Seconded by Dr. E. E. Davis, Avon).

DR. MATHER PFEIFFENBERGER, Alton: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. J. Howard Maloney as Second Vice-President. (Motion seconded by Dr. J. J. Moore, Chicago, and carried.) (The ballot was cast and the President declared Dr. Maloney elected.)

THE PRESIDENT: Now we come to the part of the program that is always difficult, but there is always a great deal of rejoicing in the House when it comes up and that is the nomination for Secretary-Treasurer.

DR. W. E. KITTLER, Rochelle: I wish to nominate Dr. Harold M. Camp to succeed himself as Secretary-Treasurer. He has done a mighty good job and should be continued in office. (Seconded by Dr. J. J. Moore, Chicago).

DR. FRED MULLER, Chicago: I move that the nominations be closed and the President be instructed to cast the affirmative ballot for Dr. Harold M. Camp as Secretary-Treasurer. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried). (The President cast the ballot and declared Dr. Camp elected).

THE PRESIDENT: The next item on the agenda is the Election of Councilors, Councilors from the third district, sixth, ninth and tenth districts retiring.

DR. BORNEMEIER: The Chicago caucus would like to place in nomination for Councilor of the Third District Dr. R. C. Oldfield. (Seconded by Dr. O. W. Rest, Chicago).

DR. ROBERT HAYES, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. R. C. Oldfield as Councilor of the Third District. (Motion seconded by Dr. A. J. Linowiecki, Chicago, and carried). (The ballot was cast and the President declared Dr. Oldfield elected).

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. A. M. Vaughn as Councilor of the Third District to succeed himself. (Seconded by Drs. Fred Muller and O. W. Rest, Chicago).

DR. WARREN FUREY, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. A. M. Vaughn as Councilor of the Third District. (Motion seconded by Dr. J. J. Moore, Chicago, and carried). (The ballot was cast and the President declared Dr. Vaughn elected).

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. John L. Reichert as Councilor for the Third District, to fill the unexpired term of Dr. H. Prather Saunders which expires in 1952. (Seconded by Dr. Anders Weigen, Chicago.)

DR. HAROLD W. MILLER, Chicago: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. John L. Reichert as Councilor for the Third District. (Motion seconded by Dr. O. W. Rest, Chicago, and carried). (The ballot was cast and the President declared Dr. Reichert elected.)

THE PRESIDENT: Nominations for Councilor of the Sixth District are in order, Dr. F. Garm Norbury retiring.

DR. GEORGE L. DRENNAN, Jacksonville: I would like to nominate Dr. Warner H. Newcomb,

Jacksonville, as Councilor for the Sixth District. (Seconded by Dr. E. E. Davis, Avon).

DR. E. E. DAVIS, Avon: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Warner H. Newcomb as Councilor for the Sixth District. (Motion seconded by Dr. E. H. Weld, Rockford, and carried). (The ballot was cast and the President declared Dr. Newcomb elected.)

THE PRESIDENT: Nominations are in order for Councilor of the Ninth District, Dr. Charles O. Lane, retiring.

DR. H. A. FELTS, Herrin: I wish to place in nomination the name of Dr. B. E. Montgomery, Harrisburg, to fill the place of Dr. Charles O. Lane, as Councilor of the Ninth District. (Seconded by Dr. W. E. Kittler, Rochelle).

DR. CHARLES E. AHLMS, West Frankfort: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. B. E. Montgomery as Councilor of the Ninth District. (Motion seconded by Dr. I. H. Neece, Decatur, and carried). (The ballot was cast and the President declared Dr. Montgomery elected.)

THE PRESIDENT: Nominations are in order for Councilor of the Tenth District, Dr. G. C. Otrich retiring.

DR. J. S. TEMPLETON, Pinckneyville: I wish to place in nomination the name of Dr. W. W. Fullerton, Steeleville, as Councilor of the Tenth District. (Seconded by Dr. Mather Pfeiffenberger, Alton).

DR. I. H. NEECE, Decatur: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. W. W. Fullerton as Councilor of the Tenth District. (Seconded by Dr. Frank M. Hagans, Lincoln, and carried. (The ballot was cast and the President declared Dr. Fullerton elected.)

THE PRESIDENT: Nominations are in order for Delegates to the American Medical Association, to take office on January 1, 1952 and serve for a term of two years, the terms of the following expiring: Robert H. Hayes, Chicago, Fred H. Muller, Chicago, Mather Pfeiffenberger, Alton, Harlan English, Danville, and Everett P. Coleman, Canton.

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. H. Kenneth Scatliff, Chicago. (Seconded by Dr. O. W. Rest, Chicago).

DR. A. M. VAUGHN, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. H. K. Scatliff, Chicago, as delegate to the American Medical Association. (Motion seconded by Dr. O. W. Rest, Chicago, and carried). (The ballot was cast and the President declared Dr. Scatliff elected.)

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. Fred H. Muller to succeed himself. (Seconded by Dr. Charles H. Phifer, Chicago).

DR. PERCY E. HOPKINS, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Fred H. Muller, Chicago, as delegate to the American Medical Association. (Motion seconded by Dr. Anders Weigen, Chicago, and carried). (The ballot was cast and the President declared Dr. Muller elected).

DR. E. E. DAVIS, Avon: I wish to place in nomination the name of Dr. Mather Pfeiffenberger, Alton, to succeed himself. (Seconded by Dr. E. H. Weld, Rockford).

DR. C. M. FLEMING, Rushville: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Mather Pfeiffenberger, Alton, as delegate to the American Medical Association. (Motion seconded by Dr. J. J. Moore, Chicago, and carried). (The ballot was cast and the President declared Dr. Pfeiffenberger elected.)

DR. A. E. DALE, Danville: I would like to place in nomination the name of Dr. Harlan English to succeed himself. (Seconded by Dr. C. M. Fleming, Rushville).

DR. E. H. WELD, Rockford: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Harlan English, Danville, as delegate to the American Medical Association. (Motion seconded by Dr. Walter C. Blaine, Tuscola, and carried). (The ballot was cast and the President declared Dr. English elected.)

DR. E. S. HAMILTON, Kankakee: I should like to place in nomination the name of Dr. E. P. Coleman, Canton, to succeed himself. (Motion seconded by Dr. Percy E. Hopkins, Chicago).

DR. HAROLD W. MILLER, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. E. P. Coleman, Canton, as delegate to the American Medical Association. (Motion seconded by Dr. O. W. Rest, Chicago, and carried). (The ballot was cast and the President declared Dr. Coleman elected.)

THE PRESIDENT: The next item on the agenda is the election of Alternate Delegates to the American Medical Association, to take office on January 1, 1952 and serve for a term of two years, the terms of the following expiring: H. Kenneth Scatliff, Chicago, Eugene T. McEnery, Chicago, Irving H. Neece, Decatur, L. S. Reavley, Sterling, and Edward H. Weld, Rockford.

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. Eugene T. McEnery, Chicago, as Alternate Delegate to the American Medical Association in place of Dr. Scatliff. (Seconded by Dr. Harold W. Miller, Chicago).

DR. FRED H. MULLER, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Eugene T. McEnery, Chicago, as Alternate Delegate to the American Medical Association. (Motion seconded by Dr. W. S. Bougher, Chicago, and carried.) (The ballot was cast and the President declared Dr. McEnery elected.)

DR. BORNEMEIER: The Chicago caucus would like to place in nomination as Alternate Delegate the man who organized the special flight to the A.M.A. at

San Francisco, Dr. Elmer V. McCarthy, in place of Dr. Eugene T. McEnery. (Seconded by Dr. J. J. Moore, Chicago).

DR. WARREN FUREY, Chicago: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Elmer V. McCarthy, Chicago, as Alternate Delegate to the American Medical Association. (Motion seconded by Dr. J. J. Moore, Chicago and carried.) (The ballot was cast and the President declared Dr. McCarthy elected.)

DR. A. F. GOODYEAR, Decatur: I would like to place in nomination the name of Dr. I. H. Neece, Decatur, to act as Alternate to Dr. Mather Pfeiffenberger. (Seconded by Dr. E. E. Davis, Avon).

DR. C. P. BLAIR, Monmouth: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. I. H. Neece, Decatur, as Alternate Delegate to Dr. Mather Pfeiffenberger. (Seconded by Dr. Harold W. Miller, Chicago, and carried.) (The ballot was cast and the President declared Dr. Neece elected.)

DR. GEORGE E. KIRBY, Spring Valley: I would like to place in nomination the name of Dr. L. S. Reavley, Sterling, as Alternate Delegate to the American Medical Association. (Seconded by Dr. E. E. Davis, Avon).

DR. FRED H. MULLER, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. L. S. Reavley, Sterling, as Alternate Delegate to the American Medical Association. (Motion seconded by Dr. J. J. Moore, Chicago, and carried. (The ballot was cast and the President declared Dr. Reavley elected).

DR. J. H. MALONEY, Rockford: I wish to place in nomination the name of Dr. E. H. Weld, Rockford, as Alternate Delegate to the American Medical Association. (Seconded by Dr. E. E. Davis, Avon.)

DR. W. E. KITTLER, Rochelle: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. E. H. Weld, Rockford, as Alternate Delegate to the American Medical Association. (Motion seconded by Dr. I. H. Neece, Decatur, and carried). (The ballot was cast and the President declared Dr. Weld elected).

THE PRESIDENT: The next order of business is the election of Standing Committees. The first committee to be elected is Medical Service and Public Relations. Under the constitution and by-laws the personnel of this Committee is named by the Council and approved by the House. The present committee personnel recommended by the Council is Percy E. Hopkins, Chairman, Edwin S. Hamilton, Kankakee, and Everett P. Coleman, Canton.*

DR. MATHER PFEIFFENBERGER, Alton: I move that the Committee personnel as named be approved. (Motion seconded by Dr. J. J. Moore, Chicago, and carried.)

THE PRESIDENT: Nominations are in order for the Medico-Legal Committee, two members to be elected each year for a three year term, the terms of Drs. Oscar Hawkinson and A. L. Nickerson expiring.

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. Richard Greening, Chicago. (Seconded by Dr. J. J. Moore, Chicago).

DR. H. K. SCATLIFF, Chicago: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Richard Greening, Chicago, as a member of the Medico-Legal Committee. (Motion seconded by Dr. J. J. Moore, Chicago and carried). (The ballot was cast and the President declared Dr. Greening elected.)

DR. CHARLES ALLISON, Kankakee: I would like to nominate Dr. A. L. Nickerson, Kankakee, to succeed himself. (Seconded by Dr. J. J. Moore).

DR. E. S. HAMILTON, Kankakee: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. A. L. Nickerson, Kankakee, as a member of the Medico-Legal Committee. (Motion seconded by Dr. Fred H. Muller, Chicago, and carried.) (The ballot was cast and the President declared Dr. Nickerson elected.)

THE PRESIDENT: Nominations are in order for the Committee on Medical Education and Hospitals, one member elected each year for a three-year term, the term of Dr. Willard O. Thompson, Chicago, expiring.

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. Willard O. Thompson to succeed himself. (Seconded by Dr. J. R. Wolff, Chicago).

DR. ROBERT H. HAYES, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Willard O. Thompson, Chicago, as a member of the Committee on Medical Education and Hospitals for a term of three years. (Motion seconded by Dr. Joseph Sodaro, Forest Park, and carried). (The ballot was cast and the President declared Dr. Thompson elected.)

THE PRESIDENT: The next Committee is Medical Benevolence, one member elected each year for a three year term, the term of Dr. Oscar Hawkinson, expiring.

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. Robert H. Hayes as a member of the Committee on Medical Benevolence for a term of three years. (Seconded by Dr. H. K. Scatliff, Chicago).

DR. HAROLD W. MILLER, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Hayes. (Motion seconded by Dr. O. W. Rest, Chicago, and carried). (The ballot was cast and the President declared Dr. Hayes elected.)

THE PRESIDENT: I think we should hear a word from Dr. Oscar Hawkinson who has held this position for years and who has run this fund from practically nothing up to the sizable sum it is today.

DR. HAWKINSON: Mr. President and Members of the House of Delegates: I did not expect to be

*Later in this Session the Committee personnel was increased from three to five members.

called on and I do not know what to say to you. This Benevolence Fund has been in operation for about ten years. I can very well remember when John Nagel stood in this House and said we were being nice to every one else, it was time we did something for ourselves. That is the origin of the benevolent fund. Then came the time when John passed away and some one else had to take over. One Sunday Dr. Berghoff came into the Council and without consulting me said, "Hawkinson is going to be Chairman of the Benevolence Fund". I said all right. I had a good idea that we could raise by popular subscription enough money, at least a half million dollars, and to use the income from that sum, to take care of our needy. You remember the rest. The entire membership was approached to get a one dollar from each member. We got $10,000. In my Branch, the Aux Plaines, we got $2500; Englewood gave $500, Will-Grundy gave $500. We thought we made a failure and more or less we did. It is a strange thing to me sometimes that doctors are the only people in the world who are afraid to invest in their own business.

We have had very pathetic cases to take care of. I think we are all happy that we can give to these people fifty dollars a month. There came along a time when we thought we would have to do differently. Three or four years ago this House of Delegates voted to take five dollars out of our dues. This year Dr. Camp said we are getting along very well. I sincerely hope that this fund will not go along only for another year but for five or six years until we get some money. God only knows what is going to happen. You may be surprised to know that some men who once lived in opulence are receiving aid from the fund. My own preceptor left his widow in absolute poverty and I was very happy I could do something about that.

I have enjoyed working with the State Society and the Chicago Medical Society has been one of the joys of my life. I am grateful to all of you for having had the privilege of serving you.

DR. MATHER PFEIFFENBERGER, Alton: I move a rising vote of thanks to Dr. Hawkinson. (Motion seconded and carried).

DR. H. K. SCATLIFF, Chicago: I would like to have the record show that we gave a rising vote of thanks to Dr. Hawkinson for his wise guidance as Councilor and as a member of the Benevolence Fund Committee.

THE PRESIDENT: Thank you Dr. Hawkinson; we all feel a deep obligation to you for the many services you have rendered the Chicago Medical Society and the State Society.

Nominations are in order for the election of two members of the Committee on Medical Testimony, the terms of Warren W. Furey, Chicago, and M. T. Horsman, Salem, expiring. Two members are elected each year for a four year term.

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. John H. Gilmore as a member of the Committee on Medical Testimony for a term of four years. (Seconded by Dr. O. W. Rest, Chicago).

DR. WARREN FUREY, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. John H. Gilmore, Chicago, as a member of the Committee on Medical Testimony for a term of four years. (Motion seconded by Dr. Percy E. Hopkins, Chicago, and carried. (The ballot was cast and the President declared Dr. Gilmore elected).

DR. J. S. TEMPLETON, Pinckneyville: I would like to place in nomination the name of Dr. M. T. Horsman, Salem, to succeed himself. (Seconded by Dr. I. H. Neece, Decatur).

DR. C. M. FLEMING, Rushville: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. M. T. Horsman, Salem, as a member of the Committee on Medical Testimony for a term of four years. (Motion seconded by Dr. E. E. Davis, Avon, and carried). (The ballot was cast and the President declared Dr. Horsman elected.)

THE PRESIDENT: Nominations are in order for two members of the Grievance Committee, Dr. E. H. Weld, Rockford, and Dr. Percy E. Hopkins, Chicago, retiring. Two are elected each year for a three year term.

DR. J. H. MALONEY, Rockford: I would like to place in nomination the name of Dr. E. H. Weld, Rockford, to succeed himself. (Seconded by Dr. A. M. Vaughn, Chicago).

DR. L. S. GREENWOOD, Rockford: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. E. H. Weld, Rockford, as a member of the Grievance Committee. (Motion seconded by Dr. E. E. Davis, Avon, and carried.) (The ballot was cast and the President declared Dr. Weld elected).

DR. BORNEMEIER: The Chicago caucus would like to place in nomination the name of Dr. Percy E. Hopkins, Chicago, as a member of the Grievance Committee to succeed himself. (Seconded by Dr. Robert H. Hayes, Chicago).

DR. WARREN FUREY, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Percy E. Hopkins, Chicago, as a member of the Grievance Committee for a term of three years. (Motion seconded by Dr. Harold W. Miller, Chicago, and carried.) (The ballot was cast and the President declared Dr. Hopkins elected.)

THE PRESIDENT: The next order of business is fixing the per capita assessment for 1952.

DR. CHARLES P. BLAIR, Monmouth: The Council recommends that the dues be not decreased.

DR. WARREN FUREY, Chicago: That is in the report of the Reference Committee on the report of the Chairman of the Council.

THE PRESIDENT: We will wait on that and pass to the next item on the agenda, the selection of a meeting place for the 1952 annual meeting.

DR. CHARLES P. BLAIR, Monmouth: There is a suggestion of the Council to the House of Delegates that this body should set up for at least two years in advance for each meeting. If there is no objection, and

as far as I know there is none, the meeting place can be set up for three years or five years, but the Council suggests that you set up for two years.

THE PRESIDENT: That will also come up in the report of the Reference Committee on the Report of the Chairman of the Council.

We will now pass to the reports of the Reference Committees and action upon same. The first report will be from the Committee on Reports of Officers.

DR. W. A. MONAGHAN, Taylorville: The Reference Committee has considered the reports of the President, the President-elect, and the Secretary-Treasurer of the Illinois State Medical Society.

1. *Harry M. Hedge, M.D., President:* It is the opinion of the Committee that no one has ever given more generously of his time. His report is that of a president who was well groomed for his office by years of experience, who was meticulous in his attention to detail, who was and is a master craftsman in the art of public relations, a virtue of manifest importance to a president of the Illinois State Medical Society in this day. At any gathering of medical men in the state of Illinois the past year, at even meetings of the smallest committees, one did not have to look for Dr. Hedge, one simply knew he was there.

For his sincerity of purpose, for his huge contribution to organized medicine and for his performance of a colossal enterprise in the most accomplished manner, we thank Dr. Hedge, we congratulate him and we wish him Godspeed in his status as past president of the best state medical society of the land.

(DR. MONAGHAN: I move that this portion of the report be approved. (Motion seconded by Dr. J. J. Moore and carried).

2. *C. Paul White, M.D., President-elect:* History is replete with examples of great men who are likewise humble individuals and the reference committee senses in the report of the President-elect, C. Paul White, the commendable attribute of humility. He is alert to the high standards set by his predecessor and his major aim will be to see they are maintained. We will welcome as our new executive a man of scholarly attainments and an enviable professional reputation.

The reference committee salutes Dr. C. Paul White, our President-elect and leader for the ensuing year, knowing full well that the confidence reposed in him will receive his most conscientious endeavor on behalf of the membership of our Society.

(DR. MONAGHAN: I move the adoption of this portion of the report. Seconded by Dr. E. E. Davis, Avon and carried).

3. *Harold M. Camp, M.D., Secretary-Treasurer:* The voluminous duties of the Secretary-Treasurer of the Illinois State Medical Society are obvious in the perusal of his report. The reference committee finds evidence of sound financial condition and the customary smooth running administrative work.

It is suggested by the committee that perhaps an itemized account of the expenditures of the educational committee and the committee on medical service and public relations might be interesting to the membership, inasmuch as they represent a major portion of payments.

The excellent administrative work in connection with the office of the secretary-treasurer is made possibly only because of the untiring efforts, the unceasing energy and the phenomenal ability of Dr. Harold M. Camp. The reference committee is aware that some recognition must be due a man who has devoted almost 30 years of his life to organized medicine as our executive secretary-treasurer, but we are also certain that this recognition could never become a reality through the agency of mere words.

It is our considered opinion that we have in our very midst that long sought, but heretofore never found, truly indispensable man. We thank Dr. Camp for the successful completion of another year in his executive capacity and we express the sincere desire that he will be with us for many years to come.

(DR. MONAGHAN: I move the acceptance of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

Respectfully submitted,

W. A. MONAGHAN, M.D., Taylorville, Chairman
R. G. OLDFIELD, M.D., Oak Park
A. J. LINOWIECKI, M.D., Chicago
R. M. WATROUS, M.D., Waukegan

DR. MONAGHAN: I move that the report be approved in its entirety. (Motion seconded by Dr. J. J. Moore, Chicago, and carried.

THE PRESIDENT: Thank you Dr. Monaghan for a very good report.

The next report will be that of the Committee on Reports of Councilors.

DR. WARREN W. FUREY, Chicago: Your Reference Committee wishes to present the following report:

Your Reference Committee met to consider the reports of the Chairman of the Council and of the individual Councilors. Because of the amount of material offered for the consideration of the Committee and because of the controversial nature of some of this material we should like to submit this report in two parts: (1) The report of the Chairman as published in the Handbook together with the supplementary report and, (2) the reports of individual Councilors.

I. We should like to commend the Chairman of the Council for the excellence of his report and for the outstanding work he has done not only in preparing the report but for his part in the orderly efforts of the Council during the past year. Comment should be made on some of the highlights of the report, particularly as it pertains to Council activities through the year.

1. We note with approval the commendation and thanks recommended to the Councilors for their regular attendance at Council meetings and for their sincere and honest efforts in the interest of organized medicine in the State of Illinois.

2. We wish to commend the Council further for its efforts to secure more efficient operation of the business

of the Society through the establishment of committees within the Council to consider specific matters before reporting to the Council; for the establishing of a single purchasing agency; for the setting up of an Advisory Committee to evolve a policy on any matter that requires immediate action; and for the Public Relations contribution in joining the Chamber of Commerce of the State of Illinois. We in medicine expect much of the public, and we in medicine should do our part in activities of the public.

3. We noted with interest the comments and commendations on the activities of the Chairman of the Medical Officer Procurement Service for Illinois and of the Advisory Committee to the Illinois Public Aid Commission.

4. Commendation too, to the "Illinois Plan" and to the Blue Shield Plans in Illinois for their continuing effort.

5. The comments regarding the annual meeting are well taken and the recommendation of the Chairman of the Council that the House of Delegates authorize the naming of the places for meetings in 1952 and 1953 at this meeting of May, 1951, and that they authorize the Council to fix dates for these two years is concurred in. The thought was expressed that the two year period should be extended probably to three years, if further study warrants.

(DR. FUREY: Mr. President, I move the adoption of this section of the report. Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

6. Comment on the activities of the Grievance Committee is approved. We concur in the recommendation that we disseminate information of the fact that we have a Grievance Committee. Wide dissemination of such information would be a most valuable contribution to our all-out Public Relations effort.

(DR. FUREY: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. O. W. Rest, Chicago, and carried).

7. The Committee concurs in the comments relative to the State Department of Public Health, the outstanding general practitioner, the Auxiliary of the Illinois State Medical Society, the Committee on Military Affairs and Emergency Medical Service, the investigation of the Illinois State Medical Society by the F.B.I., the Committee on Rural Medical Service, on the Illinois Medical Journal and the Scientific Service and the Postgraduate Education Committees.

8. We concur in the favorable comments relative to the efforts of the secretary, Dr. Camp, Mrs. Zimmer, Dr. Van Dellen, Mr. John Neal, Mr. James Leary, Miss Fox and the individual Councilors and recommend a vote of thanks by the House of Delegates to these individuals. (DR. FUREY: I move the adoption of this portion of the report. Motion seconded by Dr. H. K. Scatliff, Chicago, and carried).

9. The matter of the recent demands of the osteopathic profession contained in the Handbook and in the supplementary report of the Chairman of the Council was considered at length and in detail. Several members of the Society appeared before the Committee and expressed their views on this very controversial subject. Resolution: There was full accord in the opposition to the enactment of Senate Bills 267, 268 and 269 and in the approval of the action taken by the Medical Examining Committee with respect to the application of the Chicago College of Osteopathy.

There was substantial opposition to the "so-called compromise" of Senate Bill No. 598, enlarging the Medical Examining Committee to include five doctors of medicine, one osteopath and one chiropractor, all duly licensed to practice in the state.

A letter from the Rock Island County Medical Society expressing opposition to the compromise was presented. Other opposition was presented by your Chairman and by members of the Committee.

Dr. Hopkins, Chairman of the Medical Service and Public Relations Committee, and Dr. Blair, Chairman of the Council, presented the attitude of the Committee and of the Council. The present status of the bills was submitted. It was stated that many legislators have criticized the adamant and persistent opposition of organized medicine to efforts to settle this controversy which has been presented to every session of the legislature over the past several years. Other pertinent arguments were also presented.

Your committee is of the opinion that the opposition to compromise is reasonable and sincere; we are equally impressed with the honesty, sincerity and reasonableness of the Medical Service and Public Relations Committee and of the Council of the Illinois State Medical Society. We further are of the opinion that the members of the Council and of the Medical Service and Public Relations Committee are, by reason of experience and years of service, better acquainted with the problem than most of us. We, therefore, recommend concurrence in their action by adoption of the resolution previously adopted by the Council of the Illinois State Medical Society.

(DR. FUREY: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. Richard Greening, Chicago, and carried).

10. Your Committee approves the recommendation that dues for membership in the Illinois State Medical Society remain the same for the coming year as for the past year.

(DR. FUREY: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried.)

11. Your Committee concurs in the recommendation that dues for members entering military service be remitted from the date of their entry into service.

It was pointed out that dues for 1951 had been set at the meeting of the House of Delegates in May, 1950 and it was assumed that this recommendation would become effective for 1952. Your committee and witnesses appearing before it, were unanimous in their opinion that the Society should remit dues retroactive to January 1, 1951. It was the further considered opinion of the Committee that the Society, which has the privilege of levying dues, also has the privilege of remitting such dues.

A further, favorably received recommendation was that members in military service should receive the Journal of the Society free.

Your Committee, therefore, recommends adoption of the recommendation of the Council, effective as of January 1, 1951, and that men in military service received the Journal of the Illinois State Medical Society free.

(DR. FUREY: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, and carried).

II. *Reports of Individual Councilors*

Your Committee discussed the material contained in the Handbook. We should like to compliment the Councilors on the excellence of their work and to urge their continued effort in behalf of organized medicine at the local level.

Of particular interest, reports from most Districts contained some reference to the Public Relations program. This increasing Public Relations effort is one of the most important present-day concerns of organized medicine, and its furtherance should be encouraged.

The report from the Third District contained much interesting information on the activities of the Chicago Medical Society, the Society is to be commended on its outstanding efforts.

In closing, we should like again to extend the gratitude and appreciation of the House of Delegates to the Council and to the Councilors for their splendid effort in behalf of organized medicine.

(DR. FUREY: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. C. M. Fleming, Rushville, and carried).

Respectfully submitted,

WARREN W. FUREY, M.D., Chairman
E. T. McENERY
F. J. STEWART
E. P. BURT

DR. FUREY: Mr. President, I move the adoption of this report as a whole. (Motion seconded by Dr. O. W. Rest, Chicago, and carried).

THE PRESIDENT: May I take this opportunity to introduce to you Dr. George Lull, Secretary of the American Medical Association.

DR. LULL: I thought I could visit the House of Delegates of my own Society without saying anything. I just came down to see if I could learn something for the American Medical Association, as I heard this described as the best medical society in the United States. We have felt the influence and thinking of this Society because of the caliber of the delegates you send to the A.M.A. They form a very important part in the formation of the governing regulations of the A.M.A. I think after this next meeting of the House of Delegates of the A.M.A. we are going to see a little change in size because of the re-apportionment. I think from now on we must insist that the members must be present before we count them. I find a good many of them have not been living because I get letters from widows when I write concerning a lapse in dues. There will be a little difference in the size of the House. We want to keep the voice of this Society felt in that House.

We have changed the meeting place of the interim session from Houston to Los Angeles for a number of reasons as you saw in the papers.

We are looking forward in June to a very successful meeting if the registration beforehand means anything. Three months ago we had 10,700 individuals and that means wives and everyone who needs a hotel room, and remember we get a large contingent from Philadelphia, New York and Atlantic City and surrounding New Jersey who do not need hotel rooms but who attend the meeting. There has not been a room left on the Boardwalk for months. We are looking forward to a very successful meeting.

THE PRESIDENT: It is very refreshing to get a few words from Dr. Lull.

The next report will be from the Reference Committee on Reports of Standing Committees.

DR. DAVID B. FREEMAN, Moline: Mr. President and Members of the House of Delegates: Your Reference Committee on Reports of Standing Committees begs leave to report on:

First, the Committee on Medical Service and Public Relations: On reviewing the report of this Committee, we are overwhelmed with the vast amount of detail and work required in the performance of the duties of this committee. The Reference Committee feels that this group is entitled to much gratitude from the Illinois State Medical Society for the excellent manner in which all the problems which confronted them were handled. We earnestly suggest that all members of the House of Delegates read and study this report as published in the Handbook for the House of Delegates.

The Public Relations phase of this committee was ably handled by the director and contacts were made with many groups outside of the medical field. It is of untold value to the State Society that friendly relations exist.

The Legislative work was coordinated by John W. Neal, general counsel for the Society and executive secretary of this committee. They are in close touch with all legislative matters affecting the medical profession.

The Committee urges all members of the Illinois State Medical Society to contact their representatives whenever urged or notified by this committee. The Speakers' Bureau has been ably taken care of.

Civil Defense: New responsibilities occasioned by the present conflict have added more work to our State Society. The Committee on Emergency Medical Service is rendering excellent service, cooperating with the civil defense director of the Chicago area — one of the interesting parts of this program being the Civil Defense Program.

The Woman's Auxiliary should be most highly complimented for their activities politically as well as for their financial assistance to the Benevolence Fund of the State Society.

Again we can report that we are heartily in accord with the selection of the outstanding general practitioner, Dr. Ernest E. Davis of Avon. It was delightful

to listen to his remarks at the first meeting of the House of Delegates and we wish him Godspeed and a long and happy life.

The continued battle against the antivivisectionists should be commended. Distribution of pamphlets under direction of the Committee should be continued and Health Councils as recommended by the A.M.A. should be instituted.

(DR. FREEMAN: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. Richard Greening, Chicago, and carried).

2. Medico-Legal Committee: The Reference Committee accepts this report in full and is pleased that there was little need for this, and expresses gratitude for the services rendered members of the profession.

(DR. FREEMAN: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. Richard Greening, Chicago, and carried).

3. Committee on Archives: This Committee is deserving of gratitude for work accomplished, and for work yet undone since this is a perpetual job the end of which is not in sight.

(DR. FREEMAN: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. Richard Greening, Chicago, and carried).

4. Committee on Medical Education and Hospitals: The report of this committee is very interesting and informative. It entails a great deal of labor by its members who are justly entitled to commendation and gratitude from this Society. May we suggest that all members of the House of Delegates study this report carefully. Much information is given relative to (1) the general hospital situations, the cost of hospitalization, the role of the hospital in medical education and the general practitioner, all of which is excellent.

Relative to internships and residences, this is without a question a problem which faces many hospitals. The Committee discussed this at great length and I shall read a report to the Committee.

(Report)

After much discussion your Reference Committee recommends that this Committee ask the House of Delegates to recommend to the American Medical Association to exert its influence on medical schools to cause distribution of interns to all qualified hospitals in these United States, the apportionment being based on the number of beds in each hospital.

The Committee accepts the report on the medical schools of Illinois as well as part-time vs. full-time in clinical medicine.

The Committee discussed at length the problem of health insurance. The statement that Blue Cross and Blue Shield continued to expand their activities might have been expanded to give some definite information relative to its growth.

The statement that the Blue Cross Plan in Chicago lost $2,000,000 in 1950 might be further clarified that there was a surplus and the organization was solvent.

In paragraph six there might be a challenge to the statement that the Blue Cross and Blue Shield have attempted to dictate to the profession. It should be stated that every trustee of the Blue Shield Plan is a physician, and the control of the Blue Cross is in the hands of physicians. The new rule of prescribing for a three day period in hospitals might have given cause to the statement that they are scrutinizing the drugs that the doctors use. It is obvious that since the Illinois Plan and the other plans throughout the state are of our own origin, they are worthy of our support and they are the challenge to socialized medicine.

The Postgraduate Medical Education, the report on the Osteopathic problem and the nursing problem are all acceptable.

DR. FREEMAN: Mr. President, I move the approval of this portion of the report. Motion seconded by Dr. H. K. Scatliff, Chicago).

DR. CHARLES H. PHIFER, Chicago: I wish to express my appreciation to Dr. Freeman and the members of the Reference Committee for their report. I would, however, like to take exception to that part of the report of the Committee on Medical Education and Hospitals which appears in the Handbook in the last paragraph on Page 86 and the first two and a half paragraphs on Page 87. (Pages 49 and 50, July issue Illinois Medical Journal.) This section of the Committee's report deals with the policies of the College of Medicine of the University of Illinois. It states that the College of Medicine of the University of Illinois is rapidly changing its faculty from part time to a full time faculty, that most of the physicians of the state are opposed to full time teachers. This is obviously incorrect since out of a faculty of 900 members, not over 50 in the clinical division are full-time teachers. Medical schools like individuals have reputations to protect. This House of Delegates which has long been known for its broad democratic decisions should, therefore, give careful consideration to such statements as this before they are adopted. I have personally been connected with this school for many years, first as a graduate and later as a member of the faculty. In the years since it has been a part of the University of Illinois it has grown to be one of the largest and best medical schools in the world. Its graduates are located all over the world. Its faculty has been very carefully selected and among them are many of the leading scientific medical minds in the different specialties of medicine. Each of these has given generously of his time not only to teaching but to scientific medicine whenever called upon to make a contribution to your medical program. Likewise, this is true of many of its graduates. The trustees and the faculty of the University not only have a very keen knowledge of the problem of teaching but of the School's public relations standing.

Regardless of the number of applicants considered for appointment to the faculty or the amount of pressure from without, they have always tried to limit their participation in the practice of medicine to the care of the indigent. Their appointments to the faculty are given to men best qualified in their particular fields, and who would serve the School and the public to the best interest of all concerned. In view of these facts I think this House of Delegates owes much to the Board of Trustees and the faculty of the

College of Medicine for its constructive program. I also believe that careful consideration should be given to such statements as were made in this report before they are endorsed by this House of Delegates.

In view of these facts I believe this portion of the report of the Committee on Medical Education and Hospitals should either be deleted or postponed for further consideration, and I so move.

DR. W. E. KITTLER, Rochelle: I would like to make a motion to table this amendment.

THE PRESIDENT: I think that is not necessary.

DR. KITTLER: There is a motion before the House. A motion to table precedes any other motion. (Seconded by Dr. Mundt).

THE PRESIDENT: There is a motion to table this portion of the report of this Committee until further investigation can be made and until the next meeting.

DR. PHIFER: I have no desire to interfere with the Reference Committee's report. I think they have done excellent work. If you care to support my statement then delete that portion of the report of the Committee on Medical Education and Hospitals which appears in the last paragraph on Page 86 and the first two and one-half paragraphs on Page 87.

DR. WARREN FUREY, Chicago: A motion to table is not debatable.

THE PRESIDENT: We will have a rising vote.

DR. KITTLER: My motion to table referred to the portion Dr. Phifer mentioned in his discussion.

THE PRESIDENT: Dr. Kittler please come to the microphone and clarify your motion.

DR. KITTLER: My motion was to table the portion Dr. Phifer mentioned in his discussion.

THE PRESIDENT: There is a motion before the House.

DR. G. HENRY MUNDT, Chicago: I know this should not be discussed but inasmuch as there is a question this may be permissible. If one will open the book to page 86 and consider the last two paragraphs on 86 and the end of the report on 87, that is what this debate is on.

THE PRESIDENT: The question before the House is on tabling this amendment.

(The motion to table was carried).

(The last paragraph on 86 and the first two and one-half paragraphs on 87 are to be stricken from the report).

THE PRESIDENT: Dr. Freeman, will you continue with your report.

DR. FREEMAN: 5. Committee on Medical Benevolence: The Committee recommends the acceptance of this report and with it the gratitude of our Society to the members of this committee.

(DR. FREEMAN: Mr. President, I move the approval of this portion of the report. Motion seconded by Dr. Warren Furey, Chicago, and carried).

6. Committee on Medical Testimony: Your Reference Committee accepts this report. Our only comment seems to be that this committee has evolved a workable plan to care for its problems. Our gratitude to them.

(DR. FREEMAN: Mr. President, I move the approval of this portion of the report. Motion seconded by Dr. Richard Greening, Chicago, and carried).

7. Grievance Committee: We are pleased to note that this committee has not been overburdened by activity — something which speaks well for the profession. This committee has real opportunity for service in establishing better relationship between the doctor and the dear public.

(DR. FREEMAN: I move the approval of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

Chairman, FRANK F. MAPLE

Respectfully submitted,

DAVID B. FREEMAN, M.D., Chairman
FRANK F. MAPLE, M.D.
RICHARD GREENING, M.D.
T. G. KNAPPENBERGER, M.D.

DR. FREEMAN: I move the approval of the report as a whole. (Motion seconded by Dr. H. K. Scatliff, Chicago).

DR. WALTER STEVENSON, Quincy: I still think we did not accomplish what Dr. Phifer wanted. He wanted to table that portion of the Reference Committee's report pertaining to the University.

THE PRESIDENT: It was stated by the maker of the motion that it was the portion of the report referred to the Reference Committee and the amendment by Dr. Phifer.

(Motion to accept the report as a whole carried).

THE PRESIDENT: The next report will be from Committee "A" on Reports of Council Committees.

DR. G. HENRY MUNDT, Chicago: Your Reference Committee presents the following report:

Educational Committee: Your Reference Committee was very pleased to note the receipt of the gold statuette presented to Health Talk by Television Forecast. It has been the opinion of your Committee in hearing and seeing the broadcasts put out by the Educational Committee of the Illinois State Medical Society that they were educational to a high degree and excellent public relations for medicine.

Your Reference Committee considered the subject of ethical clearance for broadcasts; however, knowing that a resolution was introduced at the first meeting of the House, have refrained from making a recommendation. We feel that the Educational Committee has done an exemplary piece of work.

(DR. MUNDT: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

Fifty Year Club: Your Reference Committee was very pleased to note the number of members of the Fifty Year Club as of April 1, 1951. In Chicago, 150, downstate 238, a total of 388.

This Committee has been very fortunate in having as its chairman since its inception that staunch old oak, Andy Hall.

(DR. MUNDT: I move the approval of this portion of the report. Motion seconded by Dr. C. M. Fleming, Rushville, and carried).

Medical Economics Committee: Your Reference Committee has studied the report of the Committee

on Medical Economics and feels that articles such as those mentioned in the report being published is of great importance, and would urge that more articles referring to the economic aspect be incorporated in the Journal.

(DR. MUNDT: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

Committee on Physical Therapy: Your Reference Committee commends the Committee on Physical Therapy for making abstracts of significant articles on physical medicine.

(DR. MUNDT: I move the approval of this portion of the report. (Motion seconded by Dr. E. E. Davis, Avon, and carried.)

Post-Graduate Education: Your Reference Committee while not actually amazed, was very pleased to note the larger number of speakers supplied by this Committee for the authorized post-graduate sessions. Your Reference Committee feels that we are in a period of development of transmission of scientific programs by telephone, and suspects that next year numerous programs will have been supplied to county and district societies in this manner. Your Reference Committee agrees with the Committee Report that the loss of Dr. Robert S. Berghoff as chairman is regrettable.

(DR. MUNDT: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried.)

Scientific Service: A perusal of the report of this Committee will impress anyone with the number and competence of the speakers supplied for the county societies applying for the service. The supplementary list of speakers will doubtless be kept up to date and we highly commend the committee for the amount of work which they have done.

(DR. MUNDT: I move the acceptance of this portion of the report. Motion seconded by Dr. Richard Greening, Chicago, and carried.)

DR. MUNDT: This report is signed by Drs. Darrell H. Trumpe, V. V. Rockey, and G. Henry Mundt. Dr. Robert Mustell was not present to sign the report after it was typewritten. I move the approval of the report as a whole. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

THE PRESIDENT: We will now have the report of Committee "B" on Reports of Council Committees.

DR. JAMES H. HUTTON, Chicago: The Reference Committee presents the following report:

1. The Illinois Public Aid Commission:

(a) Printed Report: The Committee reviewed the published report of the Illinois Public Aid Commission committee and expresses its appreciation of the work done by the committee and of its efforts to improve the services and to raise the fee bill to something more nearly commensurate with the services rendered.

(b) Supplementary Report: The Committee also appreciates the points made in the supplementary report and the fact that it has to be indefinite because of the uncertainty of pending legislation.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

2. The Advisory Committee to the United Mine Workers: The Committee's report reviewed the progress, step by step, of this program, pointing out that the services rendered to the miners and their dependents have steadily increased. Since the resumption of the program, July 1, 1950, the extension of care has been done cautiously. It is regretted that the fee bill appears to be geared to that of the Veterans' Administration, but this is a matter about which the Committee has not yet been able to do anything.

We feel that this report should be approved and the Committee commended for its work.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

3. The Committee on Voluntary Prepayment Plans for Medical and Surgical Care: This masterly report was preceded by an enormous amount of work on the part of the committee. We feel that this report should be compulsory reading for every member of the Society. The Committee has handled this entire subject in what your Reference Committee regards as a very statesmanlike manner. The report shows that great strides have been made in persuading people to provide their own protection. This will make the plans of the socializers more difficult of accomplishment.

We recommend that the House of Delegates accept this report and commend the committee for its work.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried.)

4. The Committee on Mental Hygiene: The report, while not lengthy, indicates that much has been accomplished.

We recommend the adoption of the report and the commendation of the Committee.

(DR. HUTTON: I move the adoption of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

5. Committee on Constitution and By-Laws: Dr. Warren W. Furey, Chairman of the Committee on Constitution and By-Laws, appeared before your reference committee and explained the reasons for the proposed changes in the constitution and by-laws, as embodied in the printed report of that committee and also in its supplementary report.

Your Reference Committee recommends that the House of Delegates adopt these changes.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried.)

DR. HUTTON: The report is signed by R. F. Millet, M. M. Hoeltgen, E. F. Neckermann and James H. Hutton. I move the adoption of the report as a whole. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

THE PRESIDENT: The next report will be from Committee "C" on Reports of Council Committees.

DR. BERNARD KLEIN, Joliet: The Committee presents the following report:

1. Committee on Cancer Control: In reviewing this report, your Reference Committee was impressed by the well organized effort displayed by all agencies concerned in the fight against cancer. The medical profession has taken its rightful leadership in this effort.

The program of education, as provided by the various agencies mentioned in the report, has resulted in an awakened public interest. It has been further pointed out that satisfactory progress has been made in providing a program of professional education in the establishment of cancer clinics throughout the state, and in enlisting the aid of the nursing and dental professions.

It is to be hoped that the marshalling of resources made available should be increasingly directed by both the lay and medical groups working as a team towards the goal of solving the whole cancer problem.

(DR. KLEIN: I move the adoption of this part of of the report. Motion seconded by Dr. W. S. Bougher, Chicago, and carried.)

2. Advisory Committee on Fetus and Newborn: The report of the above committee speaks for itself and requires no comment.

(DR. KLEIN: I move the adoption of this portion of the report. Motion seconded by Dr. E. H. Weld, Rockford, and carried.)

3. Committee on Tuberculosis Control: In reviewing the report of the above committee, it is our opinion that it presents an overall picture of efforts made at control which gives promise of success in the eradication of tuberculosis.

A member of this tuberculosis control committee appeared before this group and objected to portions of the report. Inasmuch as it will not detract from the effectiveness of the report as a whole it is recommended that the paragraph at the bottom of page 170 beginning with the words, "The Chicago Medical Society made known, etc." and the points made under it, ending with the words, "Meetings in the Chicago area", on page 171, and paragraphs one and two on page 173, beginning with the words, "The work of your Committee" and ending with, "No reasonable request ever made to this organization was declined", be deleted.

(DR. KLEIN: I move the adoption of this portion of the report. Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried.)

4. Committee on Venereal Disease Control: The reviewing committee acknowledges the appraisal of the venereal disease problem as presented in this report. It indicates that there is a marked improvement as shown by the decreases in the reported cases, compared to other years, as a result of the effectiveness of the newer methods of treatment.

(DR. KLEIN: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

5. Advisory Committee to the Veterans' Administration: In reviewing this report your Reference Committee noted the satisfactory relationship that exists between the Illinois State Medical Society and the Veterans' Administration.

(DR. KLEIN: I move the adoption of this part of the report. Motion seconded by Dr. W. S. Bougher, Chicago, and carried).

6. Committee on Military Affairs and Emergency Medical Service: The report of this committee concerns itself with the development of the medical phase of civil defense. The implications of the uncertain international situation, as pointed out here, should serve to stimulate our readiness to accept the heavy responsibilities imposed on the medical profession.

The plans as submitted in this report, while comprehensive, appear to be largely in the formative state. It is hoped that the blue print of civil defense will be implemented by a real and effective organization of all the resources of the medical profession.

The plea that every member of the Illinois State Medical Society play his part and accept his share of responsibility will find a ready response, because the members of the medical profession have never failed to live up to their high ideals.

(DR. KLEIN: I move the adoption of this part of the report. Motion seconded by Dr. E. H. Weld, Rockford, and carried).

Respectfully submitted,
BERNARD KLEIN, M.D., Joliet, Chairman
J. H. MALONEY, M.D., Rockford
KARL VEHE, M.D., Chicago
JOHN R. WOLFF, M.D., Chicago

DR. KLEIN: I wish to take this opportunity to thank the members of my committee for their fine cooperation. I wish to move the adoption of the report as a whole. (Motion seconded by Dr. C. M. Fleming, Rushville, and carried.)

THE PRESIDENT: The next report will be from Committee "D" on Reports of Council Committees.

DR. A. F. GOODYEAR, Decatur: The Reference Committee presents the following report:

1. Committee on Rural Medical Service: It is the feeling of your Reference Committee that the Committee on Rural Medical Service has made a thorough, overall survey in its report.

The voluntary insurance program initiated by various interested groups reveal excellent progress "To the Right".

Your Committee urged more publicity in rural high schools, small universities and colleges, regarding the farmer-doctor loan fund. This is a sound fundamental "grass roots" program for solving rural medical personnel shortages. At the same time promotion of nursing could, or should be projected, as well as the auxiliary services, such as x-ray and laboratory technicians.

It is gratifying to know that the number of hospital beds for acute cases is ample.

The problems of the care of chronically ill will continue with population longevity. This is a community responsibility, which, by tactful stimulation of interest through community organizations, particularly the churches, in establishing and creating group housing and nursing care where among their own age and

disability groups, they become happier, healthier and more satisfactorily adjusted.

(DR. GOODYEAR: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

2. Crippled Children's Clinic Committee: Your Reference Committee commends the comprehensive and detailed report, but would suggest that contact with the physician who has been in charge be preserved and continued.

(DR. GOODYEAR: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried.)

3. Industrial Health: The industrial health situation continues to merit constant vigilance and thoughtful study. Every effort should be made to sustain the Council's criticism of placing this problem under the Department of Labor, and Senate Bill #396, now before the Illinois Assembly warrants our immediate active support, because it places the industrial workers' welfare under the Department of Public Health.

Your Committee feels that the handicapped and disabled worker should be treated and restored to active work, commensurate to his ability, as early as possible.

The moral and professional responsibility lies wholly with the physician in these cases.

By delegating the medical care of industrial workers to the Department of Public Health, for the benefit of labor itself, there will be less tendency to socialistic trends.

We highly compliment the Committee on Industrial Health on its positive opinion on this matter.

(DR. GOODYEAR: I move the adoption of this portion of the report. Motion seconded by Dr. O. W. Rest, Chicago, and carried.)

4. Maternal Welfare Committee: Your Reference Committee commends the Maternal Welfare Committee's complete thought-provoking report. Their foresight in the event of atomic attack is outstanding.

(DR. GOODYEAR: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried.)

5. Ethical Relations Committee: The Reference Committee is in harmonious accord with the Ethical Relations Committee's brief and gratifying report.

We also commend the medical profession of the State of Illinois for their good will, unity and public relations.

(DR. GOODYEAR: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

6. Committee on Nursing: Your Reference Committee fully agrees with the report of the Committee on Nursing, and urgently suggest that the Woman's Auxiliary to the Illinois State Medical Society, aid in a revival program on the basic concepts of nursing. The ability to execute and carry through physician's orders, individual care and comfort of patients and the personal satisfaction experienced through service to others as was so admirably brought to public recognition by Florence Nightingale, should be noticeably stressed.

Too many registered nurses are employed in physicians' offices. Such nurses could be replaced by trained medical technicians and assistants, releasing these nurses for more essential positions in their field of activity.

(DR. GOODYEAR: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

Respectfully submitted,
FRANK E. BIHSS, M.D.
JOSEPH SODARO, M.D.
B. K. LAZARSKI, M.D.
A. F. GOODYEAR, M.D., Chairman

DR. GOODYEAR: I thank the Committee that has helped me. I move the adoption of this report as a whole. (Motion seconded by Dr. C. M. Fleming, Rushville, and carried).

THE PRESIDENT: The next report will be from the Committee on Resolutions and on reports of the Editors, the Editorial Board and Journal Committee, Committee on Scientific Work, President of the Woman's Auxiliary, and Advisory Committee to the Woman's Auxiliary.

DR. S. M. GOLDBERGER, Chicago: The Reference Committee will first report on the reports of Committees assigned to them.

1. President of the Woman's Auxiliary: The report of the President of the Woman's Auxiliary, Mrs. Carl Sibilsky, was read with interest. We note that their work during the past year has been carried out with a great amount of success. The money that has been collected to be used for the Benevolence Fund has been greater than in previous years. This money is to be used for the care of unfortunate and impoverished physicians or their families and is work to be proud of. We wish the women of the Auxiliary continued and even greater success for the coming year.

2. Report of the Editors of the Illinois Medical Journal and the Editorial Board and the Journal Committee: The Committee believes that the Editors are continuing to do a fine job, and are looking forward to making further improvement in the Journal. The Committee has held several additional meetings the past year with much thought toward improving the quality of the Journal. The Committee is to be complimented on their fine work and on their aim in keeping the articles in the field of general medicine.

3. Report of Committee on Scientific Work: *Whereas*, the outstanding efforts of the Committee on Scientific Work, headed by Dr. Coye C. Mason as Chairman and Director of Exhibits, has produced for the Illinois State Medical Society outstanding examples of scientific progress, and the group of scientific exhibits at the 1951 annual meeting of the Illinois State Medical Society represent the best in the field of medical progress and research.

Be it resolved, that the House of Delegates extend to Dr. Mason and his committee (Dr. Hugh A. Flack, Dr. Arkell M. Vaughn, Dr. Lawrence W. Peterson, Dr. Dwight E. Clark, and Dr. Leo M. Zimmerman) a vote of commendation and appreciation.

The Committee reviewed the exhibits and found that they were excellently appointed, very well attended, and the scientific descriptions were unusually clear and visible to all. The exhibitors were pleased with the attendance and the attention given the exhibits. The general program included many subjects that were of general interest and practically all of the members who attended were well satisfied with the material, method of presentation, and the accuracy of the schedule that was maintained.

(DR. GOLDBERGER: I move the adoption of this portion of the report. Motion seconded by Dr. W. S. Bougher, Chicago, and carried).

Report of the Resolutions Committee: The Committee was of the opinion that in the future those presenting resolutions before the House of Delegates appear before the Reference Committee so that they would acquaint the Committee relative to all the facts in that particular resolution. I hope that will be carried out in the future. It was a real hardship on the Committee to reach sometimes correct conclusions without all the facts in the case.

Resolution No. 1. introduced by Dr. Walter C. Bornemeier, Chicago, *Sales Promotion Methods Used by Pharmaceutical Houses.* (See Proceedings of First Sessions of House of Delegates, July issue of Illinois Medical Journal, for the details of this and subsequent resolutions).

(DR. GOLDBERGER: I move the approval of this resolution. Motion seconded by Dr. E. E. Davis, Avon, and carried).

Resolution No. 2. introduced by Dr. Walter C. Bornemeier, Chicago, *Relief from Payment of Dues in the American Medical Association by Retired and Emeritus Members.*

DR. GOLDBERGER: The Reference Committee recommends that this be referred to the Constitution and By-Laws Committee.

THE PRESIDENT: Dr. Furey would you speak to this?

DR. WARREN FUREY: It appears to me that this is rather well explained in the report of the Secretary and I think the matter can well be referred to the Constitution and By-Laws Committee. We will get together with the Secretary and check upon it.

THE PRESIDENT: Inasmuch as this has been referred by the Reference Committee to the Committee on Constitution and By-Laws, it will be passed up and given to that Committee.

DR. GOLDBERGER (continuing)

Resolution No. 3. introduced by Dr. W. O. Thompson, Chicago, *Opposition to Federal Subsidy of Medical Schools.*

(DR. GOLDBERGER: The Reference Committee approved this resolution and I move the adoption of this portion of the report. Motion seconded by Dr. Harlan English, Danville, and carried).

Resolution No. 4. introduced by Dr. L. S. Reavley, Sterling, *Salaries Paid to Physicians in the Illinois Department of Public Health.*

DR. GOLDBERGER: It was voted to substitute for this resolution the one that appears on Page 88 of the First Session of the House, which the Committee adopted. I move the adoption of this portion of the report. (Motion seconded by Dr. E. H. Weld, and carried).

Resolution No. 5, introduced by Dr. Charles H. Phifer, Chicago, *Clearance For Radio and Television Programs.* (See Page 89).

DR. GOLDBERGER: Last year a resolution was adopted in the 1950 annual meeting, reading as follows:

Whereas, physicians in Illinois frequently are asked to discuss health and medical care over radio and on television, and

Whereas, an increasing number each year are asked to present subjects such as medical care under a compulsory system, and

Whereas, a physician so appearing speaks not only as an individual but as a representative of the 10,000 members of the profession who compose the Illinois State Medical Society,

Therefore Be It Resolved, that the House of Delegates of the Illinois State Medical Society in session on this 23rd day of May, 1950, do hereby urge that all physicians discussing matters of health and medical care especially over radio or on television programs, first, obtain for themselves and the subject matter to be presented, ethical clearance from the Educational Committee, or the Committee on Medical Service and Public Relations of the Illinois State Medical Society before making their broadcast.

The Committee approved the resolution with the deletion of the word "especially" and the addition of the paragraph, "Failure to obtain clearance from the county medical society or the State Educational Committee by any individual will constitute a basis of instituting charges for unethical conduct."

This year this resolution was re-introduced by Dr. Phifer (See Page 89).

I move you the adoption of this portion of the report. The Committee was desirous of hearing from the Educational Committee or some member of the Committee. (Motion seconded by Dr. Charles Allison, Kankakee).

THE PRESIDENT: Dr. Blair would you like to talk to this resolution?

DR. CHARLES P. BLAIR, Monmouth: It is the intent of the Educational Committee and the Committee on Medical Service and Public Relations that you as delegates will take home to your own society the facts just stated. There are too many men wanting to appear on radio. You must remember you are speaking for 10,000 men and not individually. We have no criticism of the report. We want you to take it home and promulgate it the membership of your society, that you just cannot talk on the radio and television without getting clearance. There are too many men talking on the radio and making statements which should not be made.

DR. G. L. DRENNAN, Jacksonville: It is the intent of the Educational Committee to add one more admonition, that you be careful of your sponsors and look them over before you talk.

QUESTION: Does that refer only to radio or to men who give talks before lay organizations?

DR. DRENNAN: We do not intend to make it more difficult for men appearing before the Rotary and woman's organization. It is not intended for that. You are speaking as an individual to a small group.

DR. H. K. SCATLIFF, Chicago: Attention has been called to the fact that many doctors of Chicago go on television, radio, etc. and I want to point out that the Chicago Medical Society is working in close cooperation with the Educational Committee. It takes three weeks for clearance. Some of these requests come in and want some one in three days. It is difficult to tell them that they have to wait for three weeks. We would like an emergency set-up so that we may have clearance as far as the doctor is concerned in a shorter time. I would like to have the Committee draw up the remarks of Dr. Drennan made so that the Committee will have something for guidance.

DR. JOSEPH T. O'NEILL, Ottawa: There is nothing more to say except to emphasize the remarks of the first two speakers. The Committee has given this considerable attention. We have had many problems in regard to this subject. Our purpose in bringing it on the floor is to make you all aware that there is such a resolution and that it has been interpreted. We hope for your cooperation.

DR. KARL L. VEHE, Chicago: I have nothing to add excepting to say that such a resolution will furnish some protection to the unwary physician who might be invited to speak and accept. The possibility of getting into trouble not with this society but with the public is great. Dr. Drennan's admonition that he look over his sponsors very carefully before he accepts the invitation is a good one. The Educational Committee can be of great help.

DR. G. HENRY MUNDT, Chicago: Mr. President, first I should like to ask the gentlemen proponents whether they really feel that a man should be declared unethical because he does speak before radio or appear before television unauthorized. Is that really your intention? Should this not be the function of the Educational Committee rather than an intent of punishment? I just cannot see it. I do not believe you can ever make the thing stick. I am certain if I by any chance should appear before radio unauthorized, and I am not going to, that they would throw me out of the profession, I would carry it to the courts and I would win. This is not solid. It is the type of thing they have been doing in Washington. I think you should start an educational campaign. This Society should not even contemplate doing it; if you do, you are falling in line with some of the things we opposed last fall. I think you had better delete it. I do not know whether any of you will favor what I have said. Don't go too far. I think this is one of the most dangerous things I have ever seen come into this House of Delegates.

THE PRESIDENT: I believe Dr. Blair has a few more remarks.

DR. BLAIR: The question of appearance before various organizations will be taken care of if the word "especially" be deleted.

In regard to what Dr. Mundt said, the Educational Committee has no intention of inflicting punishment. Men appear before radio and television. Chicago has excellent men who are given clearance but there are a few men in Chicago and at least two down state who are appearing on the radio with a very obnoxious program and one the Chicago Medical Society has been unable to touch and we have been unable to do anything. We would like to have some ruling on this. If you say we cannot discipline a man, perhaps some one in authority can tell him he is not on the beam.

There is one other point, that is immediate clearance and I am glad Dr. Scatliff brought that up. The Educational Committee has been able to clear a man within a matter of hours, but the Committee asks for clearance of the man and his material. Our greatest difficulty has been with the man who wants to ad lib and some of the finest of our speakers have made some erroneous statements. The Educational Committee can clear and call a man within twenty-four hours. I am sure the Committee on Medical Service and Public Relations can do that. We would like to have some means of saying, "I am responsible to some one for appearing on the radio". We are asking for teeth and we don't care whether they are short or long.

DR. MUNDT: Relative to the discussion which was just made, I know there is a man in Chicago whose address is given on the radio and whose telephone number is given. I think that is definitely unethical. It seems to me that the Ethical Relations Committee can take care of that. All you need to do is to bring him in. I believe that may happen downstate, but I do not want to see because of a single act, a man automatically declared unethical. It is a bad policy. If I had the temerity and I have, I will move that the word unethical be deleted from the report of the Committee. (Motion seconded by Dr. Walter Baer, Peoria).

I had not the privilege of reading the resolution. There was one other word deleted, and I move as a substitute motion the elimination of the last sentence in its entirety. (Seconded by Dr. Walter Baer, Peoria).

DR. GOLDBERGER: Read that portion.

DR. W. E. KITTLER, Rochelle: It seems to me if you delete it you take the teeth out of the resolution.

DR. E. S. HAMILTON, Kankakee: I move you that the resolution be tabled. (Motion seconded by Dr. W. E. Kittler, Rochelle, and carried).

Dr. Goldberger continuing with the report.

Resolution No. 6, *Relief from full payment of dues, local, state and A.M.A.* (See Page 89), introduced by Dr. Allison Burdick, Aux Plaines Branch. The Committee recommends that this be referred to the Committee on Constitution and By-Laws, and I so move. (Motion seconded by Dr. E. E. Davis, Avon).

THE PRESIDENT: It cannot be effective this

year and cannot be acted on until the next meeting of the House of Delegates.

(Motion carried).

DR. GOLDBERGER:

Resolution No. 7, *Support of H.B. 311 (The Illinois Civil Defense Bill,)* introduced by Dr. Leo P. A. Sweeney, Chicago. (See Page 89). This H.B. 311 passed the House at Springfield yesterday. The Committee approves this resolution. Mr. President, I move the adoption of this report. (Motion seconded by Dr. O. W. Rest, Chicago).

DR. EARL BLAIR, Chicago: This bill passed the House yesterday and will go to the Senate.

(Motion carried).

DR. GOLDBERGER: Resolution No. 8, *Misrepresentations by the St. Louis Post-Dispatch in reference to the position and purposes of The Macoupin County Medical Society and The Illinois State Medical Society in the matter of the Community Memorial Hospital at Staunton,* introduced by Dr. John Ubben, Staunton. (See Page 89). The Reference Committee approves this resolution and I move the adoption of this portion of the report. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

Resolution No. 9, *Disapproval of any practice of medicine by industry that might destroy physician-patient relationship,* introduced by Dr. E. H. Weld, Rockford (See Page 91).

Due to lack of facts regarding this resolution, since none of those sponsoring the resolution appeared before the Committee, the Committee recommends that this be referred to the Council for study. I move the adoption of this portion of the report. (Motion seconded by Dr. Warren Furey, Chicago, and carried).

Resolution No. 10, *Medical Benevolence Fund: The Substitution of a "pay-as-go" Plan in Place of Present Endowment Fund,* introduced by Dr. E. H. Weld, Rockford. (See Page 91). The Reference Committee disapproved of this resolution. Mr. President, I move the adoption of this portion of the report. (Motion seconded by Dr. O. W. Rest, Chicago, and carried).

Resolution No. 12, Supplemental report to the Members of the House of Delegates:

The Committee on Industrial Health calls to your attention Senate Bill No. 396 now pending before the General Assembly of the Illinois State Legislature.

This bill is sponsored by the Illinois State Medical Society and restores to the State Health Department by legislative enactment the responsibility and function of administering industrial hygiene in Illinois.

This action has been taken by the State Medical Society because of its concern when in December, 1950, the Governor of Illinois by executive order abolished the Division of Industrial Hygiene in the State Health Department and allowed this function to be assumed by the State Department of Labor.

Your Committee on Industrial Health respectfully requests the House of Delegates to: (1) Express its concern regarding the delegation of medical and welfare responsibilities of state government to any agency whose major function is not primarily concerned with preventive medicine and public health. (2) To notify by direct message to each member of the state legislature the unanimous endorsement by the Illinois State Medical Society of Senate Bill No. 396, and request favorable action for enactment.

Respectfully submitted,

Joseph H. Chivers, M.D., Chairman
Richard J. Bennett, Jr. M.D.
David B. Freeman, M.D.
H. A. Vonachen, M.D.
R. I. Barickman, M.D.
O. B. Boyd, M.D.
Committee on Industrial Health

The Reference Committee approved this supplementary report of the Committee on Industrial Health, and I move that this portion of the report be adopted. (Motion seconded by Dr. Warren Furey, Chicago, and carried).

Resolution No. 11, *The Osteopathic Bills,* introduced by Dr. Charles P. Blair, Monmouth.

The Reference Committee approved the resolution to defeat Senate Bills 267, 268 and 269, and approved the report of Articles 1 and 2, and the deleting of Articles 3 and 4.

DR. WARREN FUREY, Chicago: I rise to a point of order and procedure. This resolution was referred to the Committee and we have made a recommendation, and I presume that takes in the adoption of the resolution as presented.

DR. GOLDBERGER: I move the adoption of the report as a whole which is signed by Drs. J. C. Redington, Charles Allison, Patrick H. McNulty, and S. M. Goldberger. (Motion seconded by Dr. Percy E. Hopkins, Chicago, and carried).

I also want to thank the various members of the Committee who worked 100 per cent on this voluminous task.

THE PRESIDENT: The next report will be from the Committee on Miscellaneous Business.

DR. GEORGE L. DRENNAN, Jacksonville: The Committee, consisting of Drs. Frank Deneen, Carl Steinhoff, Frank Fowler and George L. Drennan, met at 5:30 on May 22 and voted to endorse the reports of the Committee on Nutrition, the Committee on Medical History, Report of Delegates to the A.M.A., Committee to Investigate Private Practice and Interprofessional Relations Committee, as published in the Handbook, and any other matters referred by the President.

I would recommend the adoption of the report of this Committee as a whole. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

THE PRESIDENT: Dr. Furey has a report of the Constitution and By-Laws Committee.

DR. WARREN FUREY, Chicago: The House has adopted our report but that does not include the adoption of the amendments to the by-laws and constitution. Two-thirds of those present must vote favorably on the adoption of the amendments. Therefore I would like to present the amendments.

1. Amend Article IV, Section 3, *Emeritus Members,* by deleting the word "and" after thirty-five years and

substituting the words "or who", therein. The amended section will then read, "A member who has been in good standing for thirty-five years or who has reached the age of seventy, may, on recommendation of his component society, be made an Emeritus Member, and have all the rights and privileges of membership without payment of dues to the component or State Society."

I move the adoption of this amendment to the Constitution.

THE PRESIDENT: This amendment has been presented twice, having been presented on the first day. It requires a two-thirds vote for adoption. (Motion seconded by Dr. E. E. Davis, Avon, and carried.)

DR. FUREY: To amend Article IV by changing Section 7 to Section 8 and Section 8 to Section 9. I move the adoption of this amendment. (Motion seconded by Dr. O. W. Rest, Chicago, and carried).

To amend Article IV by adding a new Section 7. "*Retired Members.* Members of the Society, who by reason of age or mental or physical incapacity have retired from active practice, may on request of the component society be placed on the retired list."

Mr. President, I move the adoption of this amendment. (Motion seconded by Dr. J. H. Hutton, Chicago, and carried).

To amend Article X by adding, "The Council may authorize the remission of dues of any member on recommendation of his County Medical Society for reason. The Secretary in such cases shall recommend remission of dues by the American Medical Association."

Mr. President, I move the adoption of this amendment. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

To amend Chapter IX, Section 3 of the By-Laws, "The Committee on Medical Service and Public Relations shall consist of *three* members, by deleting the word "three" and substituting the word "five". It will then read: "The Committee on Medical Service and Public Relations shall consist of five members."

I move the adoption of this amendment. (Motion seconded by Dr. W. S. Bougher, Chicago, and carried).

To amend Article IV, Section 6 of the Constitution, *Past Service Members* by deleting the words, "become totally and permanently disabled", and substituting the words, "by reason of age or mental or physical incapacity retired from active practice".

I move the adoption of this amendment. (Motion seconded by Dr. James H. Hutton, Chicago, and carried).

One more matter referred to the Committee on Constitution and By-Laws by the Committee on Resolutions, with regard to emeritus and past service members being relieved from dues (Resolution No. 2, introduced by Dr. Walter Bornemeier — First Session of House of Delegates, July Journal). Your Committee would like to recommend the passage of the resolution previously offered. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

THE SECRETARY: I would like to get an expression of opinion from the House as to which type of Handbook they would like to have in the future.

THE PRESIDENT: All in favor of the smaller type of Handbook signify by the usual sign. (It is practically unanimous).

THE SECRETARY: It will be done accordingly.

At this time I would like to get the approval of the House to send letters of thanks to the individuals responsible for making this meeting a success and to the Hotel. We have had excellent cooperation from this hotel. Dr. Muller and his committee from the Chicago Medical Society did a magnificent job.

DR. MATHER PFEIFFENBERGER, Alton: I so move. (Motion seconded by Dr. Walter Bornemeier, Chicago, and carried).

DR. CHARLES P. BLAIR, Monmouth: Does the House fully understand about the dues, that they have taken action when they O.K.'d Dr. Furey's report?

THE PRESIDENT: The dues will be the same as for the past year, $20.00.

The next order of business will be the election of Emeritus members. The Secretary will read the list:

Brenner, F. T., Quincy, Adams County
Collins, H. O., Quincy, Adams
Davidson, W. E., Liberty, Adams
Ericson, Charles E., Quincy, Adams
Germann, Melinda C., Quincy, Adams
Hinton, Ralph T., Quincy, Adams
Miller, John E., Quincy, Adams
Ferguson, R. R., St. Petersburg, Fla., C.M.S.
Healy, M. Edward, Chicago, C.M.S.
Schmidt, Charles L., Chicago, C.M.S.
Shafer, Leland Charles, Chicago, C.M.S.
Stillians, Arthur W., Chicago, C.M.S.
Cutter, W. W., Peoria, Peoria
Meley, Margaret B., Peoria, Peoria
Stiers, Fred, East Peoria, Peoria
Souders, J. C., Rock Island, Rock Island
West, A. D., Moline, Rock Island
Knewitz, Otto William, East St. Louis, St. Clair
Leavy, C. J., Freeport, Stephenson
Beard, Charles G., Sterling, Whiteside

DR. HARLAN ENGLISH, Danville: I move they be elected to Emeritus membership. (Motion seconded by Dr. S. M. Goldberger, Chicago, and carried).

THE PRESIDENT: The next item of business is the election of Past Service members. The Secretary will read the list.

Irwin, C. H., Champaign, Champaign
Haeffner, A. W., LaGrange Park, C.M.S.
Kaplan, Emanuel M., Chicago, C.M.S.
Suino, John B., LaSalle, LaSalle
Elliott, J. Norman, Bloomington, McLean
Johnson, Frank, Eldorado, Saline
Evans, F. N., Springfield, Sangamon

DR. HARLAN ENGLISH, Danville: I move the adoption of this report and that these men be elected to Past Service membership. (Motion seconded by Dr. A. E. Dale, Danville, and carried).

THE PRESIDENT: It gives me a certain amount of pleasure and also a certain amount of regret to enter into the second part of this program, that is the induction of Dr. C. Paul White as President of the

Illinois State Medical Society. I want to express my appreciation to the Council of the Illinois State Medical Society, to every Committee and Committee chairman, and to every member of the Society in the State of Illinois for the cooperation I have received, and to the House of Delegates for its wonderful cooperation at this session. I hope that the work will go on, and I know it will go on satisfactorily and even in a better way because I have talked to Dr. White about some of his ideas for the coming year and approve them all.

If Dr. Kirby will be kind enough to escort Dr. White to the platform we will proceed.

DR. GEORGE E. KIRBY, Spring Valley: Mr. President and Members: At the downstate caucus of this body in May, 1950 it was my proud privilege to have nominated as President-Elect of the Illinois State Medical Society, Dr. C. Paul White of Kewanee. Dr. White having been duly elected, I hope that in this proud moment President Hedge you will see fit to elevate Dr. White to this high and honorable position of President of the Illinois State Medical Society.

THE PRESIDENT: Dr. White, it is certainly a pleasure, having known you for a good many years very personally, to have the privilege of handing you the official gavel of the Illinois State Medical Society and also to pin on you the badge to indicate that you are now not the President-elect but the President of the Illinois State Medical Society.

DR. C. PAUL WHITE: Gentlemen: It may be just a little different, but I am going to ask a member of this House, the Secretary of the Henry County Medical Society, to escort my wife to the platform. I just want you to know that had it not been for the cooperation and support of this little lady, I might not have been here today. I wish to present to you, the House of Delegates, Mrs. White. I hope you come to know her better. Thank you.

I likewise want to recognize the fact that a Committee from the past governors of the Illinois and Iowa Kiwanis International are here to share with me this induction, and also my very good friend of twenty-five years, my associate at home, Dr. John Boswell, who started the ball rolling in Henry County Society that resulted in my being here.

To have been elevated from the ranks of a practicing physician to the presidency of the Illinois State Medical Society must have been an honor greatly appreciated by the 110 men who have preceded me. But something tells me today that the responsibility accompanying that honor almost overwhelmed them.

I stand at the threshold of a new year, deeply appreciative of the confidence placed in me by the House of Delegates of this great society, and fully cognizant of the work that lies ahead. Your united support will assure us a successful year.

I would be out of character were I to become a sounding board for any one individual or any one group of individuals, but make certain I shall always listen attentively to any one person or group of persons of this Society who may have suggestions or advice, and I shall administer as far as my authority permits what in my opinion is for the best interest of the Society as a whole.

This is a great corporation handling several hundred thousand dollars annually, and although we have explicit confidence in the integrity and good will of our Council it does seem to many that a survey by a disinterested party for the purpose of determining the efficiency of all services rendered by the Society would be a prudent thing to do.

Our scientific progress is constant through the facilities of our five great Class A Medical Schools in Chicago, and our professional services are noted by the low mortality and morbidity rate in the state.

Politically we recognize no party but we strive to seek the services in politics of those men who are well founded in the principle of free enterprise, and who are opposed to the welfare state. We do not countenance the use of money as a medium for influencing vote, rather we place our confidence and faith in our legislature to legislate for the best interest of all the people of Illinois.

I wish to urge that each of you return to your homes and develop a postive approach to organized medicine. Instead of always speaking against something, let us tell the world more about what medicine has accomplished, and what we fully expect to be accomplished in the future if left unhampered by legislation.

May we not relax in our effort to promote a favorable public opinion for organized medicine.

During the coming year *citizenship responsibility* will be emphasized and I do mean in the manner which you render professional and public service.

Gentlemen, I may make mistakes, but with your material assistance and Divine guidance, I shall do my best.

I now declare this meeting closed *sine die*.

The meeting adjourned *sine die* at 12:30 P.M.

NEWS OF THE STATE



ADAMS

Personal.—Dr. David Rouse has become associated with Drs. Walter Stevenson, Sr. and Dr. Walter Stevenson, Jr., Quincy.

COOK

Personal.—Dr. Arthur R. Colwell, chairman of the department of medicine at Northwestern University Medical School, has been elected president of the American Diabetes Association.—Dr. Carl A. Dragstedt, professor and chairman of the department of pharmacology, at Northwestern, has been elected president of the Society for Experimental Biology and Medicine. This society has a membership of approximately 2400, engaged in research in the various fields of biology and medicine.—Dr. John M. Dorsey has been named chairman of the department of surgery at Evanston Hospital succeeding Dr. Frederick Christopher, Winnetka, who resigned to devote his entire time to private practice and clinical research.

Special Societies Elections.—At the annual meeting of the Chicago Society of Internal Medicine, May 28, the following officers were elected: Dr. Frank B. Kelly, president; Dr. Lowell T. Coggeshall, vice president; Dr. Ernest G. McEwen, secretary-treasurer; and Drs. George H. Coleman, Sidney Strauss and Howard L. Alt, members, executive committee.—The officers of the Chicago Orthopedic Society for the year 1951-1952 are as follows: Dr. Ferdinand Seidler, president; Dr. Sam W. Banks, president-elect; Dr. Donald S. Miller, vice president; Dr. William J. Schnute, secretary-treasury; and Dr. Mary S. Sherman, assistant secretary.—The Chicago Gynecological Society, at its annual meeting June 15, elected the following officers: Dr. M. Edward Davis, president; Dr. Edward M. Dorr, president-elect; Dr. A. F. Lash, vice president; Dr. Edwin J. De Costa, secretary; Dr. Harry Boysen, treasurer; Dr. Clyde J. Geiger, pathologist; and Dr. Janet Towns, editor.

Gift for New Fellowship.—A gift of $2500 from the Bristol Laboratories, Syracuse, N. Y. to Northwestern University Medical School will be used to establish a Bristol Fellowship. The fund will pay the salary of a fellow in the department of biochemistry working under the direction of Dr. E. A. Zeller.

University News.—Dr. George G. Jackson of Boston, Mass., has been appointed as assistant professor of preventive medicine at the University of Illinois College of Medicine starting July 1.

Dr. Jackson, 30, presently holds joint appointments as Milton fellow in medicine at Harvard, research fellow at Thorndike Memorial Laboratory, and assistant in medicine at Boston City Hospital.

His research experience concerns clinical and laboratory investigations in infectious diseases. He is a graduate of Brigham Young University and the University of Utah College of Medicine.

Society News.—Dr. Abel Froman gave an illustrated talk entitled "The Use of the Chest X-ray in Detecting a Masquerading Lung and Heart Condition" at the annual meeting of the Illinois Chapter College of Chest Physicians, recently. It consisted of a study of twenty cases of diaphragmatic hernia first suspected in the routine chest film and confirmed by barium studies.—Dr. Louis B. Newman, chief, physical medicine and rehabilitation service, Veterans Administration Hospital, Hines, was one of the medical participants at the Fourth Annual Conference on Aging at the University of Michigan, July 11-13. The conferences were to be on "The

Rehabilitation of the Handicapped Worker Over Forty."

N. U. Psychiatrist Named Consultant of United Nations.—Dr. Jules H. Masserman, associate professor of nervous and mental diseases at Northwestern University and scientific director of the National Foundation for Psychiatric Research, has been appointed consultant to the Secretariat of the United Nations. Dr. Masserman has been designated by the World Health Organization to present a series of lectures at universities in Europe and Scandinavia next October and November. During his stay in England, Dr. Masserman will address the British Royal Society concerning his research studies and their significance to dynamic concepts of personal and social behavior.

Dr. Bloch Goes to New York.—Dr. Robert G. Bloch, professor of medicine, section of tuberculosis and diseases of the chest, Division of Biological Sciences, University of Chicago School of Medicine, has resigned to accept the position as director of the division of diseases of the chest at Montefiore Hospital, New York City.

Northwestern Combines Departments of Chemistry and Experimental Medicine.—Dr. Richard H. Young, dean of Northwestern University's Medical School, announced today that the Departments of Chemistry and Experimental Medicine are being combined into the Department of Biochemistry.

Dr. Smith Freeman, who has been professor and chairman of the Department of Experimental Medicine, has been named chairman of the newly established Department of Biochemistry. In addition to his Doctor of Medicine degree, Dr. Freeman also holds a Ph.D. in biochemistry.

Dr. Young said the facilities, resources, nature of work and personnel of the Departments of Experimental Medicine and Chemistry in the Medical School complement each other to an unusual degree.

"Therefore," the dean pointed out, "in order to strengthen both, the two are combined into the single Department of Biochemistry, thus providing an opportunity for this Department to become one of the strongest and most versatile departments in this or any other medical school in the country."

Dr. Young also announced that Dr. George E. Shambaugh has been named professor and chairman of the Department of Otolaryngology, effective Sept. 1. He will succeed Dr. Howard C. Ballenger who will devote full-time to his private practice and to revision of a medical textbook.

Dr. Shambaugh has been associated with the Northwestern Medical School since 1941. He also is chief of Wesley Memorial Hospital's division of otolaryngology.

Physicians Win Honors.—Dr. George Clark, associate professor of neuro-anatomy, Chicago Medical School, received the Dr. M. L. Parker Award presented upon recommendation of the faculty for meritorious scientific research during the academic year 1950-1951. The presentation was made by President John J. Sheinin at the recent 37th commencement exercises of the school in recognition of Dr. Clark's original studies on the structure and function of the cerebral cortex.—Dr. Robert E. Lee has been named the recipient of the Borden Undergraduate Research Award for 1951 at the University of Illinois College of Medicine. The award represents a gift of $500. Originality and thoroughness of research are of primary consideration in selecting the winner. The award is sponsored by the Borden Company Foundation, Inc. He received the award for original work in the study of new analgesic drugs, for the demonstration that cortisone is not a centrally acting analgesic drug, and for a careful and detailed study of the reaction of schizophrenic patients to the Thorn diagnostic test. Dr. Lee recently received the doctor of medicine degree from the University of Illinois.—Fourth-year students in the University of Illinois have presented Dr. Frederick W. Hiss and Dr. Carl J. Marienfeld with the Raymond B. Allen Instructorship Awards for the 1950-1951 school year. The awards, designed to honor excellency in individual instructorship rendered by faculty members to students, are presented annually by each class in the College of Medicine. Dr. Morris Green and Dr. Max Samter were presented with awards by the third-year class. Dr. Earl W. Cauldwell received the second-year award, and Dr. Parke H. Simer received the award from the first-year class. Each of the award winners received a key in the form of a golden apple. Their names will be placed on the permanent plaque which hangs in the Chicago Illini Union.—Dr. Abe Oyamada, a resident in the department of pathology of Mount Sinai Hospital, has been awarded the Ruth Berger Reader Fellowship in the amount of $1,500 for research on hemolytic anemias. This is the second year that this Fellowship, supported by the Hematology Foundation in Chicago, has been awarded to Dr. Oyamada, who will carry on his investigations under the supervision of Dr. Israel Davidsohn, head of the department of pathology, Chicago Medical School, and director of laboratories at Mount Sinai.

DU PAGE

Personal.—Dr. D. W. Bowman, Itasca, was recently appointed to the Du Page County board of supervisors to succeed Dr. Arthur S. Webb, Wheaton, resigned.

HENRY

Personal.—Dr. F. J. Stewart, Kewanee, has been elected chairman of the Peoria regional blood center.

LAKE

New Blood Bank.—The Lake County Medical Society has instituted a Blood Bank to supply all the hospitals in Lake County. Organization of the blood bank was aided by a gift of $10,000.00 from the Blumberg family in Waukegan, Illinois, and is known as the Jacob Blumberg Memorial

Blood Bank of the Lake County Medical Society, Incorporated.

The blood bank is organized as an insurance plan for families in Lake County. Families are signed up as a unit with the promise of one member of the family to give one pint of blood when requested by the blood bank. In return for this, each family is guaranteed all the blood it may need at any time without the necessity of replacing the blood, or paying for it. Only the hospital service charge for equipment and laboratory work of $15.00 per pint of blood is made.

The Society is attempting to obtain a membership of 12,000 member families. Since in an average year, approximately 3,000 pints of blood are used in Lake County, each family will be asked for one pint of blood about once every four years.

The Blood Bank is located in Waukegan, Illinois in the Jane Dowst Emergency Hospital. Two technicians, specially trained in this field, draw and process the blood. These two technicians with a secretary, comprise the paid staff. Dr. Hugh Wilson, Pathologist, is the technical director. The majority of the Board of Directors consists of physicians from the Lake County Medical Society.

Blood is now distributed to each Hospital in Lake County and is on hand at all times. The Sheriff's Office of Lake County distributes the blood to the Hospitals, and has facilities always available to carry blood in emergencies as well.

The Lake County Medical Society considers this a direct attempt to improve public relations of the medical profession. It is believed the public will recognize the value of the service rendered.

LIVINGSTON

Society Election.—Dr. Otis Law was on June 21 reelected president of the Livingston County Medical Society at a meeting in Pontiac, and Dr. James H. Langstaff, Jr., secretary-treasurer. Dr. Charles J. Heiberger, Peoria, addressed the meeting on "Management of Bleeding During Pregnancy."

MACON

Society News.—Dr. Robert T. Tidrick, Iowa City, addressed the Macon County Medical Society recently on "Ulcerative Colitis."

MADISON

Society News.—Dr. Edmund A. Smolik, associate professor of surgery, St. Louis University School of Medicine, discussed "Aneurysms of the Skull" before the Madison County Medical Society in June.

Physician Honored.—Dr. D. D. Monroe was honored at a dinner given by the staff of St. Joseph's Hospital recently and presented him with a silver tray in recognition of his completion of fifty years in the practice of medicine. Dr. J. D. McClosky was toastmaster and Dr. M. R. Williamson made the presentation.

MARION

Society Officers.—The current officers of the Marion County Medical Society are Dr. E. F. Stephens Jr., Centralia, president; Dr. Harry D. Nesmith, Salem, vice president; and Dr. Ben H. Barbour Jr., Centralia, secretary-treasurer.

MORGAN

Society News.—Dr. David Slight, Chicago, addressed the Morgan County Medical Society recently on "The Psychiatrist and the General Practitioner."

PEORIA

Physicians Honored.—Dr. Charles Farnum Sr., Peoria, was inducted into the Fifty Year Club of the Illinois State Medical Society at a meeting of the Peoria Medical Society, June 19. At the same time, Drs. Fred Stiers, Margaret Meloy, William Cutter and L. V. Boynton were awarded life emeritus memberships. Special guests for the evening were Dr. Ralph Graham, Monmouth, a classmate of Dr. Farnum and a Fifty Year Club member himself, and Dr. Charles P. Blair, Councilor of the Fourth District, who presented the awards.

SANGAMON

New Tuberculosis Association.—Dr. Frank M. Davis, Springfield, was chosen president of the newly formed Sangamon County Tuberculosis Association at its organizational meeting, June 1. Other officers of the association are Dr. Darrell H. Trumpe, first vice president; Frank Aurelius, second vice president; Lawrence Meiklejohn, treasurer; and Mrs. Donald Schnepp, secretary.

STEPHENSON

Fifty Year Member.—Dr. Linda K. Hutchins, Freeport, was inducted into the Fifty Year Club of the Illinois State Medical Society at a dinner meeting of the Stephenson County Medical Society, June 21. The presentation of the insignia indicating fifty years of service was made by Dr. Joseph S. Lundholm, Rockford, Councilor of the First Councilor District of the Illinois State Medical Society.

VERMILION

Physicians Honored.—Dr. Otto Wellenreiter and Dr. Winifred A. Robb, both of Danville, were inducted into the Fifty Year Club of the Illinois State Medical Society at a meeting of the Vermilion County Medical Society recently. The presentation of the insignia pins and certificates was made by Dr. Harlan English, Councilor for the District.

HEALTH DEPARTMENT ACTIVITIES

New Regional Health Officer.—Dr. Jackson P. Birge has been appointed health officer of the Illinois Department of Public Health's Northwest Region, with headquarters in Rock Island. Dr. Birge

received his medical degree from the University of Oklahoma in 1931 and his master's degree in public health from the University of Michigan in 1950. Dr. Birge was in private practice from 1933 to 1942 and then entered the Army Medical Corps as a 1st lieutenant. He served overseas in the European theatre of operations for 27 months, becoming a lieutenant-colonel. From 1946 to 1947, Dr. Birge served in the Veteran's Administration in Oklahoma City and then became health officer of the Matagorda Health Unit in Bay City, Texas. Since 1948, he has served as a district health officer for the Indiana State Board of Health and as health officer of the Elkhart County Health Department.

"A Picture of Health".—The 1950 annual report of the Cook County Department of Public Health was recently released. The report appears in the form of an illustrative booklet, carrying effective divisions and presenting statistical material in an interesting, visual manner.

Decrease in Communicable Diseases.—The first half of 1951 showed decreases in 12 of the 30 major communicable diseases reported to the state Department of Public Health, as compared to the similar period last year.

Increases in 11 of the communicable diseases occurred during the six-months period while seven illnesses remained on the same level.

Most decided decreases in the half-year were in cases of whooping cough which declined from 2,064 to 596, mumps down from 5,501 last year to 4,289 this year, measles from 14,964 to 13,236, syphilis from 5,953 to 4,979, and tuberculosis from 3,832 to 3,458.

The same period saw incidence of scarlet fever rise from 1,459 to 2,037, chickenpox from 9,840 to 11,597, gonorrhea from 11,062 to 12,093, undulant fever from 235 to 252 and poliomyelitis from 69 to 83.

Typhoid fever cases numbered 24 in each of the six-months periods, tetanus remained constant at seven. Malaria and Rocky Mountain spotted fever both totaled two cases for each of the periods.

No rabies in man or smallpox were reported in either half-year.

GENERAL

Form Group for Blood Banks.—Dr. Israel Davidsohn, head of the Department of Pathology of the Chicago Medical School and Director of Laboratories at Mount Sinai Hospital, Chicago, was recently elected President of the newly formed Illinois Association of Blood Banks. Other elections were: Vice President, Dr. Max Appel, Burnham City Hospital, Champaign, Illinois; Secretary-Treasurer, Dr. A. M. Wolf, Michael Reese Research Foundation, Chicago; President-Elect, Dr. George Milles, Augustana Hospital, Chicago.

This is a non-profit organization which seeks to promote cooperation among blood banks in Illinois so that life-saving blood and plasma will be widely available in times of disaster, to establish every higher standards for blood banking, and to serve as a clearing house for questions concerning the training of personnel.

Psychiatrists Choose Officers.—At a recent meeting of the Illinois Psychiatric Society, the following were chosen to office: Dr. William H. Haines, president; Drs. Jules H. Masserman and Josephine M. Chapin, both of Chicago, vice president and secretary-treasurer, respectively; and Drs. D. Louis Steinberg, Elgin, and Alfred P. Bay, Manteno, councilors.

MARRIAGES

Dr. Joy Webster to Mr. Charles H. Bondurant, both of Chicago, June 11.

DEATHS

Earvye H. Anderson, Oak Park, who graduated at Stritch School of Medicine of Loyola University in 1918, died May 20, aged 63.

Harry S. Arkin, Chicago, who graduated at Rush Medical College in 1917, died July 8, aged 58. He was senior attending physician in medicine at Michael Reese Hospital.

Frederick O. Fredrickson, Chicago, who graduated at Rush Medical College in 1908, died July 6, aged 77. He was assistant professor of medicine (Rush), Emeritus, at the University of Illinois College of Medicine, a past president of the Illinois State Medical Society, and a member of Verdun Post, No. 472 of the American Legion.

Alexander G. Gabrielianz, Chicago, who graduated at Odessa Medical Institute, Odessa, U.S.S.R., in 1918, died June 28, aged 60.

Emory C. Gaffney, retired, Lincoln, who graduated at The Hahnemann Medical College and Hospital in 1905, died June 1, aged 66. He was a past president of the Logan County Medical Society, a member of the American Association of Railway Surgeons and the American Association of Military Surgeons.

Ludvig Hektoen, Chicago, who graduated at the University of Illinois College of Medicine in 1887, died July 5, aged 88. He was president emeritus and a founder of the Chicago Tumor Clinic, professor and head of the department of pathology at the University of Chicago from 1901 to 1932, and also had been professor emeritus of pathology at Rush Medical School.

Levi R. Illyes, Palestine, who graduated at Central College of Physicians and Surgeons, Indianapolis, Ind., in 1898, died June 12, aged 79. He had practiced medicine in Palestine for 33 years.

James H. Langstaff, Fairbury, who graduated at Illinois Medical College, Chicago, in 1904, died suddenly, July 5, aged 68. He was a member of the American College of Surgeons, the Illinois State Medical Society, and the American Medical Association.

Robert X. McCracken, retired, Belleville, who graduated at Washington University School of Medicine, St. Louis, in 1890, died June 18, aged 86. He had practiced medicine at Fayetteville and East St. Louis.

JOHN W. MONTGOMERY, Birds, who graduated at Hospital College of Medicine, Louisville, Ky., died June 22, aged 75.

JOHN T. RIESS, Red Bud, who graduated at Washington University School of Medicine, St. Louis, in 1905, died June 20, aged 81. He had practiced medicine in Randolph and Monroe Counties for 46 years.

JAMES B. ROBERTS, retired, Kansas, who graduated at the University of Pennsylvania School of Medicine in 1902, died June 7, aged 75.

HARRY SALINGER, Chicago, who graduated at Jenner Medical College, Chicago, in 1912, died April 8, aged 68. He was past president, vice president, and formerly director of the Bankers Association for Foreign Trade.

FREDERICK HERMES SCHMIDT, Woodstock, who graduated at Chicago College of Medicine and Surgery in 1911, died near Genoa City, Wis., March 12, aged 68, of injuries received in an automobile accident.

HOWARD M. SEDGWICK, Peoria, who graduated at the University of Michigan Medical School, Ann Arbor, in 1900, died June 9, aged 84. He was one of the oldest practicing physicians in Peoria.

REUBEN SEID, Chicago, who graduated at the University of Illinois College of Medicine in 1927, died July 8, aged 53.

EUGENE G. SIMPSON, retired, Naperville, who graduated at Rush Medical College in 1892, died June 7, aged 86. He organized the Naperville Health Department and served as its first health officer.

CARROLL W. STUART, Oak Park, who graduated at the University of Illinois College of Medicine in 1930, died July 1, aged 60. He was chief of maxillo-facial surgery at Oak Park and Grant Hospitals.

LILLIAN M. THOMPSON, Chicago, who graduated at The Hahnemann Medical College and Hospital in 1909, died June 14, aged 77. She had practiced medicine in Chicago for 40 years.

"FOR THE COMMON GOOD"

Health Talk Back on Air.—Since the May issue of the Illinois Medical Journal, the following telecasts have been presented by the Educational Committee over WGN-TV, Channel 9, on Tuesday evenings at 7:30 p.m.:

George Cummins, July 3, Ulcers of the Stomach.

Newton C. Mead, July 10, Does Your Back Ache? The Denoyer-Geppert Company provided equipment for this telecast.

Thomas Naughton, July 17, Contact Lenses.

Lester A. Nalefski and Sam Kruger, July 24, What the Atomic Bomb Means to You. Equipment for this telecast was made available by the Nuclear Instrument and Chemical Company.

Your Doctor Speaks Over WFJL, Thursday evenings at 7:30 p.m., carried the following transcribed broadcasts under the auspices of the Educational Committee since the June issue of the Illinois Medical Journal:

Frederick Steigmann, June 7, Jaundice.

Clifford P. Sullivan, June 14, Wearing Glasses.

Matthew M. Steiner, June 21, Is Your Child Obese?

Adolph Rostenberg Jr., June 28, Allergic Conditions of the Skin and Hot Weather Skin Troubles.

Amos J. Brown, July 5, Chest Pain and Heart Disease.

Thomas C. Douglass, July 12, Early Symptoms of Cancer of the Colon.

Hans Von Leden, July 19, Hoarseness.

Max Samter, July 26, Summer Allergies.

Here Is Your Doctor Over WCFL, Saturday mornings at 11 a.m., presented the following physicians in transcribed broadcasts under the auspices of the Educational Committee:

James H. Cross, June 16, Your Gallbladder in Health and Disease.

Herman A. Levy, June 23, Chronic Headaches.

James R. Webster, June 30, Uses of X-Ray in Skin Disorders.

Albert H. Unger, July 7, Hay Fever.

Elmer W. Hagens, July 14, Choking on Foreign Bodies.

Lectures Arranged Through the Scientific Service Committee:

George H. Rezek, Cicero, June 27, Kane County Medical Society, St. Charles, Gynecologic Endocrines, illustrated.

Robert M. Kark, Chicago, September 13, Fulton County Medical Society, in Canton, Some Factors Concerned with the General Improvement of the Nutritional Status of the Population of the U.S.A. During the Past Ten Years.

James W. J. Carpender, Chicago, September 13, Henry County Medical Society, Kewanee, Radioactive Isotopes in Therapy, illustrated.

Norris L. Brookens, Urbana, September 18, Iroquois County Medical Society, Watseka, Geriatric Nutrition.

Harry Benaron, Chicago, September 25, De Kalb County Medical Society, The Management of Occipito-Posterior Position.

Myron M. Hipskind, Chicago, September 28, McDonough County Medical Society, Macomb, Dizziness, illustrated.

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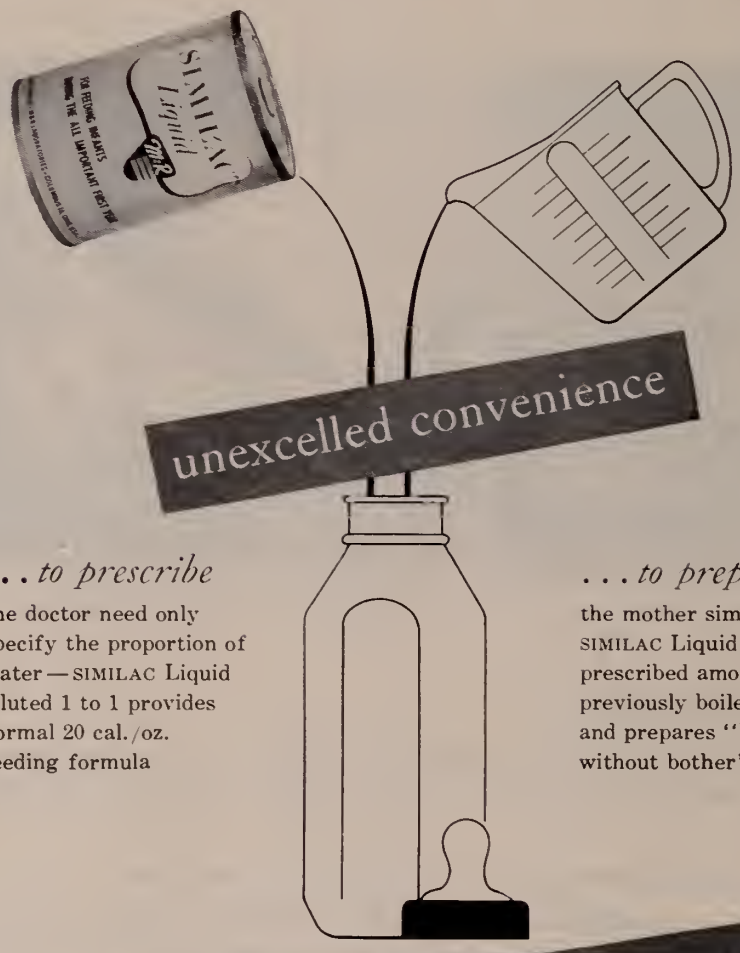
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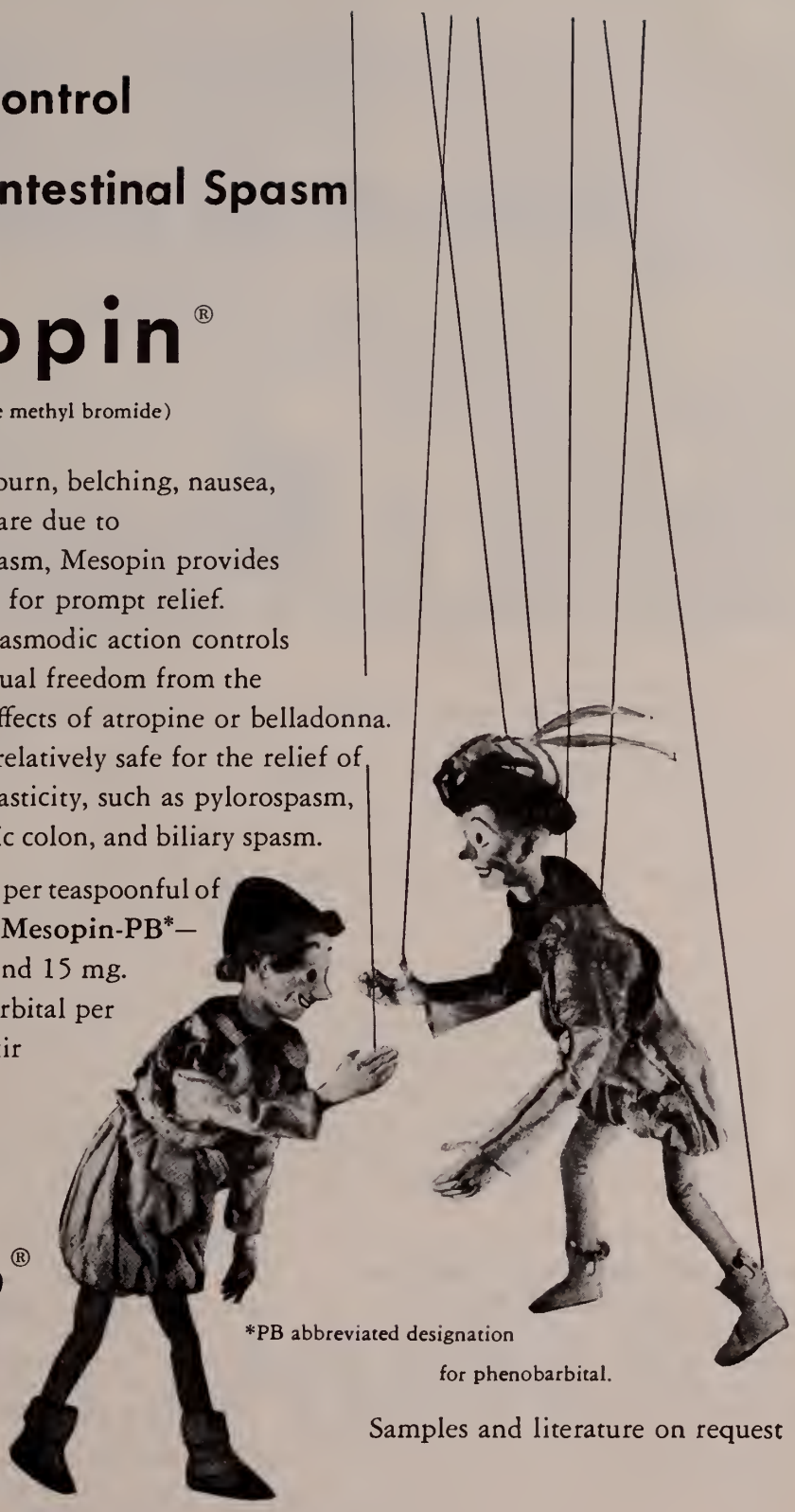
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PHYSICAL MEDICINE ABSTRACTS



REHABILITATION OF THE DISABLED

T. E. Holland, B.Sc., M.D., F.R.C.S. (Edin.)., F.R.C.S. (C) In MANITOBA MEDICAL REVIEW, 30:9:637, November 1950.

The whole field of rehabilitation is one demanding our urgent attention. The North American Indians left those who were old and feeble to die by the wayside lest they impede the mobility and safety of the tribe. Today adequate care of the disabled is seen to be one of our major medical and social problems. It is a problem which we ourselves have created. Our advances in diagnostic, therapeutic and public health measures have produced an older age group, but as Doctor Bortz, past President of the American Medical Association, has stated "the society which fosters research to save human life cannot escape the responsibility of the life thus extended. It is for science not only to add years of life but more important to add life to the years."

REFLEXES EVOKED BY COLD STIMULI IN INJURIES OF THE SPINAL CORD

Lewis J. Pollock, M. D., Benjamin Boshes, M. D., Herman Chor, M. D., Isidore Finkelman, M. D., Alex J. Arieff, M. D., Meyer Brown, M. D., and John R. Finkle, M. D., Chicago. In ARCHIVES OF NEUROLOGY AND PSYCHIATRY, 65: 5:622, May 1951.

Intrigued by the challenge of an article by Macht and Kuhn, in which it is pointed out that there is a paucity of information on the reflexes evoked by cold stimuli in spinal man, Pollock and coauthors studied such responses in their material of injuries to the spinal cord.

As was expected, the stimulus of cold, as in the case of other exteroceptive stimuli, produced reflex activity from the distal end of an injured spinal cord.

The effectiveness of the stimulus was less than that of scratch or of multiple pinprick. The responses occurred from stimulation of similar reflexogenous zones.

As was the case with other stimuli, the greatest number of muscle groups participating in the reflexes occurred with injury of the cervical portion of the spinal cord; next, with injury of the thoracic portion, and least, with injury of the lumbar portion. The greatest number of cases in which no response followed stimulation was that of injuries to the lumbar portion of the spinal cord; next, that of injuries to the thoracic portion, and least, that of injuries of the cervical portion. The frequency of crossed reflexes was least with lesions of the lumbar portion of the spinal cord, next with lesions of the thoracic region and greatest with lesions of the cervical region. Ipsilateral reflexes alone predominated.

With lesions of the cervical portion of the spinal cord, abnormal reflex activity in the upper extremities occurred from stimulation of the skin of the upper extremities. The arm and forearm were more effective reflexogenous zones than the hand, and the volar surfaces were more effective than the dorsal surfaces. The arm and forearm were the most effective zones for reflex movements of the shoulder, forearm and wrist; and the hand was the most effective for movements of the thumb and fingers. Ipsilateral and contralateral reflexes of the upper extremities were evoked from stimuli below the level of the lesion,

(*Continued on page* 44)

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in a few cases as low as the inner aspect of the thigh. Stimulation of the upper extremity resulted in reflex movements of the lower extremities in two instances, representing 5 per cent of 43 cases, whereas stimulation of the abdominal wall resulted in such reflex activity in 18 instances, representing 41 per cent of 43 cases of lesions of the cervical portion of the cord. More reflex activity resulted from stimulation of the upper than of the lower abdominal quadrants.

ELECTROTHERAPY IN EXPERIMENTALLY PRODUCED LESIONS OF PERIPHERAL NERVES

Lewis J. Pollock, M. D., Alex J. Arieff, M. D., Irving C. Sherman, M. D., Maurice Schiller, M. D., Eli Tigay, M. D., Frederick Hiller, M. D., Erich Liebert, M. D., and George K. Yacorzynski, Ph.D., Chicago, Ill. In ARCHIVES OF PHYSICAL MEDICINE, 32:6:377, June 1951.

This communication deals with the effect of electrotherapy after section of the peripheral nerves in the leg of cats and rats. The specific items studied were (1) prevention of and recovery from muscle atrophy, (2) contractures, and (3) histological changes in muscles.

The experiment was planned to obtain data regarding the efficacy of treatment upon the retardation of muscle atrophy and facilitation of regeneration of muscle and nerve. The latter was studied by observing the return of motor, sensory and reflex functions and the response to electrical stimuli. A study was made of the effect of electrotherapy upon the development of contractures.

The major original experiment was so arranged that the cats received various types of treatment. Some animals received no treatment, in order that we might have a group of controls. Massage and passive movement was the basal treatment to which other treatments were added, since it was feared that if joint changes occurred more frequently in those animals which did not have massage and passive movement a fair comparison could not be made. Thus, for purposes of comparison, there was an untreated group, a group treated with massage and passive movement, and a group treated with massage, passive movement and electricity.

The following conclusions were reached:

(1) After primary suture of one sciatic nerve in the cat, there is no statistically significant difference in the percentage loss of weight of the gastrocnemius muscle when untreated or treated by massage and passive movement combined with

(*Continued on page* 46)

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electrotherapy for 5 or 15 minutes, at varying intervals, from 30 to 180 days after operation.

(2) This was true also for secondary sutures performed 60 days after section at 135 and 180 days after suture.

(3) The same was true for bilateral primary suture of the sciatic nerves at 45 and 75 days after suture.

(4) After bilateral denervation after 30, 60, 90, and 120 days, there was a small but statistically significant larger weight of electrically treated muscles. This superior weight did not increase with time and probably may be explained on the basis of generalized lessening of the activity of the cat.

(5) Furthermore, we were unable to confirm the results of Gutmann and Guttmann in the rabbit when, after section and suture of the peroneal nerve of the cat, the tibialis muscle complex was treated by electrical stimuli. There was no retardation of atrophy or facilitation of recovery of the bulk of the muscle.

(6) The weight of the denervated gastrocnemius-plantaris complex of an extremity of the rat which was treated by electrical stimulus was uniformly greater than that of the untreated side.

(7) The failure to find any statistically significant difference between the weight of treated and of untreated denervated muscles in the cat and the uniform excess of weight of the treated denervated muscle in the rat suggests a species difference in response to electrotherapy.

(8) Greater numbers of contractures of greater severity occurred in the normal antagonistic gastrocnemius muscle when an extremity, after peroneal nerve section and suture, was treated by electrical stimuli. This also was found in the experiment upon the sciatic nerve. The cause for this finding is unknown.

(9) The gastrocnemius muscles of the cats examined 90 days after primary suture of the sciatic nerve showed marked variations in the histopathological picture. These variations were present in muscles whether treated or not.

THE PLACE OF OCCUPATIONAL THERAPY IN PHYSICAL MEDICINE

Phyllis Lyttleton, T.M.M.G., T.M.A.O.T. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 14:5:107, May 1951.

This is not a discussion of the contributions of all the members of the physical medicine team, but

(*Continued on page* 50)

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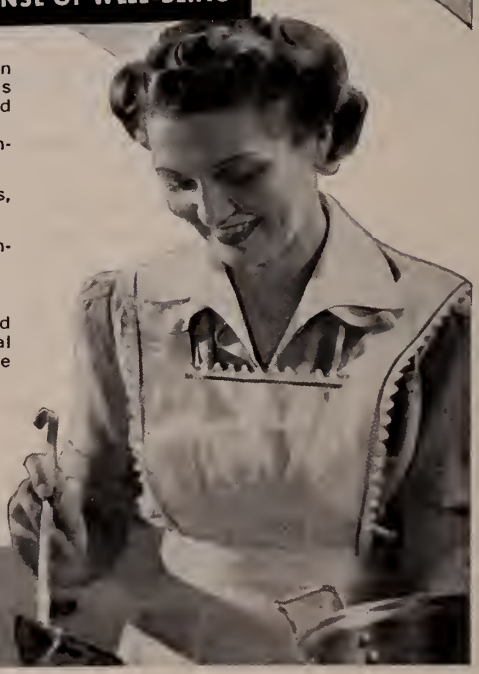
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Schaeffer, J. R., and Pulaski, E. J.:
U. S. Armed Forces M. J. 1:1447 (Dec.) 1950.

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Physical Medicine (Continued)

rather a consideration of occupational therapy with as fair an appraisal of its "cans" and "can'ts" as has been found during some years of practice in the physical field, both as physical therapist and occupational therapist.

Briefly, occupational therapy assists that part of the healing process which enables a patient to coordinate and correlate all his returning powers towards the normal. For occupational therapy to be of value it must be started early. It must begin when the patient is first able to put forth constructive effort, so that this effort may be directed immediately into the normal channel of creative work, thus preventing the formation of that barrier between physical recovery and total coordination which occurs when recovery is not immediately harnessed to function.

With regard to the more usual interpretation of coordination, that on the purely physical plane, occupational therapy provides the ideal treatment, for coordination can only be achieved by use, and the normal activity of the part is obviously its over gymnastics lies in the time factor. Fatigue best use. One advantage of occupational therapy will limit the practice period in either department, but in occupational therapy the interest and concentration required usually postpone the onset of fatigue most markedly.

For endurance there is little doubt that occupational therapy is of value. However, endurance of itself has no virtue; it is the capacity to do a certain job continuously without tiring that is the goal, and only by *doing* the job, or one very like it, can the patient's endurance be so developed that he may return to work having regained his confidence in his ability to do his job.

REHABILITATION FROM PEDIATRICS TO GERIATRICS: DISGRACEFUL LACK OF REHABILITATION FACILITIES ALLEGED

Albert A. Martucci, M. D. Editorial in THE PENNSYLVANIA MEDICAL JOURNAL, 54: 3:237, March 1951.

The purpose of a survey made by the Commission on Physical Medicine and Rehabilitation of the Medical Society of the State of Pennsylvania was to discover what services and facilities are at present available for the rehabilitation of the people of the Commonwealth of Pennsylvania.

The results shown by the hospitals that responded to the questionnaires demonstrated a woeful lack of rehabilitation facilities either on an out-patient or as an in-patient service. It has been estimated from the survey that less than one-half of one per cent of the hospital beds in the Commonwealth of Pennsylvania are devoted to any type of rehabilitation, and a conservative estimate is made that there are 10,000 persons in the state needing such services.

(*Continued on page* 52)



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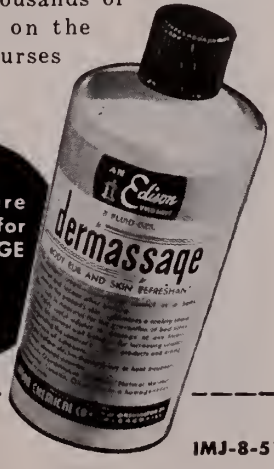
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Physical Medicine (Continued)

If we are to meet the problem of rehabilitation from pediatrics to geriatrics, it is necessary that 10 per cent of the present hospital beds be made immediately available for rehabilitation. It has been proved by the Army and Navy hospitals and the Veterans' Hospitals that miraculous results could be obtained by a rehabilitation program. Getting these patients back into society and enabling them to assume the best economic position possible in their community is a "must" in view of present-day emergencies. It has been proved that patients so rehabilitated become self-sustaining, independent, and contribute to the welfare of society as a whole rather than become burdens.

TREATMENT OF THE PYOGENIC DERMATOSES

Ray O. Noojin, M. D., Birmingham. In THE JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA, 20:8:277, February 1951.

Certain general measures may prove necessary in chronic recalcitrant cases. The possibility of an underlying diabetes mellitus or a chronic infectious focus should not be overlooked.

If the patient has not responded well, bed rest should be required. At times this may mean the difference between treatment failure or success.

Ultraviolet light applied generally as well as locally may be effectively added in an individual having recurrent bouts of folliculitis, impetigo, or furunculosis.

In the treatment of erysipelas, insist upon bed rest, force fluids, immobilize the affected part, and apply wet compresses. The use of antitoxin and ultraviolet light usually are not necessary.

Ultraviolet light locally in suberythema doses often is helpful in the treatment of sycosis vulgaris.

In treating furunculosis, advise bed rest and immobilize the affected part. If it is painful, apply local heat in the form of infrared light or diathermy. Do not traumatize or squeeze.

Among the 410 persons who died from tuberculosis in Minnesota in 1949, 259 were 50 years or older, of whom 129 were 65 years or over. Apparently the tubercle bacillus is making its land stand in old men. Of the 259 persons of 50 years or older who died in 1949, only 72 (27.8 per cent) were women. J. Arthur Myers, M.D., Journal-Lancet, April, 1950.

In more than one country in the world, in recent years, carefully planned studies into infection and morbidity rates have shown clearly that the incidence of clinically significant tuberculosis is far in excess of that which is compatible with the death rates as returned officially by the same communities. Official Records of the World Health Organization. No. 18.



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*Hamblen, E. C.: North Caralina M. J. 7:533 (Oct.) 1946

BOOK REVIEWS



THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY: W. A. Newman Dorland, A.M., M.D., F.A.C.S. Twenty-second edition; 1736 pages; 720 illustrations. W. B. Saunders Company, Philadelphia and London, 1951; price $10.00.

This new edition of the ever popular Dorland Medical Dictionary is in keeping with previous editions. The book contains 132,000 definitions, and there are more than 2,000 new words, bringing it completely up to date. This book is a must for every physician and should be on every doctor's desk, where it will be readily available for the many uses to be found daily for up to the minute definitions.

The ever present thumb index aids materially in finding the proper word and its definition. This is not only a dictionary for the physician, but is intended also for Dentists, Pharmacists, Chemists, Nurses, Veterinarians and others in the various allied professions. The 720 illustrations, including 48 plates likewise adds much to this excellent volume.

No physician's library should be considered up to date without this valuable illustrated medical dictionary always to be kept in a convenient place, for it will be used probably more often than any other book in the library. The spelling and pronunciation likewise increases its popularity.

The reviewer predicts that this new edition will be as popular as has its predecessors over a period of 51 years.

EYES AND INDUSTRY, formerly Industrial Ophthalmology by Hedwig S. Kuhn, M.D., Industrial Ophthalmologist, Hammond, Indiana. 151 Text Illustrations, including 3 color plates. Second Edition. St. Louis: The C. V. Mosby Company, 1950. $8.50.

Industrial ophthalmology refers to the numerous and diverse visual problems peculiar to industrial production.

Doctor Kuhn has become particularly well informed on the subject due to the most unusual opportunity she has because of her practice being conducted in a highly industrialized area. The doctor has written well to produce an authoritative book for oculists, who serve industrial communities.

The chapter dealing with industrial eye injuries caused by solid bodies was contributed by Albert C. Snell, M.D., of Rochester, N. Y. The appendix has a section on evaluation of visual testing techniques in industry by Henry A. Imus, Ph.D., Washington, D. C. Also an evaluation of tinted lenses by Alfred Cowan, M.D., of Philadelphia, which states that manufacturers of certain tinted lenses make fantastic, absurd and untrue claims.

Industrial surgeons need this text, industrial ophthalmologists must have it.

L. P. A. S.

A TEXTBOOK OF THE PRACTICE OF MEDICINE. By Various Authors, Edited by Frederick W. Price. Eighth Edition, Geoffrey Cumberlege, Oxford University Press, New York, 1950. $9.00.

This textbook of general medicine is the eighth edition and contains many welcome additions and revisions. Altogether there are 31 contributors from the British Isles. Numerous articles have been partially or entirely rewritten and changes in nomenclature have been made.

New articles have been added on cervical intervertebral disc, rehabilitation of paraplegics, filaria, South American blastomycosis, Reiter's disease, chronic intermittent juvenile jaundice, paroxysmal proctalgia, calci-

(*Continued on page* 56)

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Post-Hemorrhoidectomy	3 minutes
Post-Tonsillectomy	2 minutes
Simple Headache	½ - 3 minutes
Menstrual Pain	5 minutes



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1. Hoffman, Murray M., Ill. Dent. Jl., 19:439-445 (Oct., 1950)

2. McNealy, Raymond W., Ill. Med. Jl., 97:150 (Mar., 1950)

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BOOK REVIEWS (Continued)

fied pericardium, diaphragmatic hernia and atomic injuries. More space also is devoted to the sulfonamides and antibiotics but there is nothing on the newer antibiotics such as aureomycin, chloramphenicol (chloromycetin) and terramycin, nor is mention made of cortisone and ACTH. With so many authors some sections are obviously better than others but the book is well organized and adequately indexed. There is a section devoted to skin disease but it lacks photographs or diagrams. This work is not superior to the better books on internal medicine in this country, but should prove useful to students and practitioners.

T. R. V.

ETERNAL EVE: The History of Gynecology and Obstetrics, Harvey Graham, Doubleday & Company, Inc., Garden City, N. Y., 1951. $10.00.

This book is a monumental history of gynecology and obstetrics written in language understandable by the physician and layman as well. It goes back to primitive races and includes the Dayak story of Kelili who watched the male monkeys help their wives at the birth of their young. From this beginning the author takes the reader through the obstetrical history of ancient Greece, Rome, mediaeval times and even Queen Anne's fifteen pregnancies. There are the first Caesarean sections, Chapman the man midwife, early rules for using forceps and puerperal pestilence. Gynecology begins with Ephraim McDowell and the first ovariotomy.

This book has everything. Harvey Graham is the pen name of the author, Isaac Harvey Flack, editor of the British Medical Journal. He is not a gynecologist nor obstetrician but he has the facts and knows how to present them.

T. R. V.

MEDICAL TREATMENT — Edited by Geoffrey Evans, M.D., F.R.C.P. Consulting Physician St. Bartholomew's Hospital. 1398 pages. Price $20.00. Butterworth and Co. (Publishers) Ltd. London, England. The C. V. Mosby Company, St. Louis, Mo., U.S.A. 1951.

This is the first edition of a medical text designed primarily for practitioners. It is quite extensive in scope. There are 53 contributors representing some of the outstanding British physicians in the various specialties. The makeup and arrangement of the book is logical, but differs from our standard U. S. texts. There are only 51 illustrations in this very large text. The price of $20.00 seems excessive.

J. W. P.

PRINCIPLES AND PRACTICE OF OBSTETRICS: By J. P. Greenhill, M.D., Attending Obstetrician and Gynecologist, The Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, The Chicago Lying-In Hospital; Attending Gynecologist, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. New, 10th

(*Continued on page* 58)

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BOOK REVIEWS (Continued)

Edition. 1020 pages with 1140 illustrations on 864 figures, 194 in color. Philadelphia and London: W. B. Saunders Company, 1951. Price $12.00.

This is the 10th edition of this well known and widely used textbook of obstetrics. DeLee's work has been a standard in medical schools since its original publication in 1913.

In this edition Dr. Greenhill has even surpassed his previous excellent editions. Not a single page remains as it was in the last edition and the arrangement of the book has been changed. All the latest developments in obstetrics have been included. In specialized subjects he has enlisted the aid of authorities, as for example the section on "Anesthesia" compiled with the assistance of Dr. Mary Karp.

A classification of definitions and classifications of the toxemias of pregnancy, types of breech presentations, types of placenta praevia, definitions of engagement and station and definitions of low, mid, and high forceps operations are admirably presented.

Other important new material covers the physiology of the uterus, analgesia and anesthesia, toxemias of pregnancies, importance of acute infectious disease (especially German measles) and fetal erythroblastosis, to mention but a few.

This book maintains the high standards set by previous editions.

J. W. P.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

SPATIAL VECTOR ELECTROCARDIOGRAPHY — Clinical Electrocardiographic Interpretation. By Robert P. Grant, M.D., National Heart Institute, Bethesda, Maryland; and E. Harvey Estes, Jr., M.D., U. S. Naval Hospital, Bethesda, Md. 41 figures; 149 pages; June 1, 1951. $4.50. The Blakiston Company, Philadelphia 5, New York 22, Toronto 2, Canada.

PRACTICAL CLINICAL PSYCHIATRY — 7th Edition. By Edward A. Strecker, Litt. D., LL. D., Professor of Psychiatry, School of Medicine, University of Pennsylvania; Franklin G. Ebaugh, M.D., Professor of Psychiatry, University of Colorado, School of Medicine and Director, Colorado Psychopathic Hospital; and Jack R. Ewalt, M. D., Professor of Neuro-Psychiatry and Administrator of Hospitals, University of Texas Medical Branch, Galveston. Section on "Psychopathologic Problems of Childhood" by Leo Kanner, M. D., Associate Professor of Psychiatry, John Hopkins University School of Medicine. 35

(*Continued on page 60*)



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BOOKS RECEIVED (continued)

figures; 14 tables; 506 pages; June 13, 1951. $7.00. The Blakiston Company, Philadelphia 5, New York 22, Toronto 2.

AN INTRODUCTION TO MODERN PSYCHOLOGY. By O. L. Zangwill. 20 diagrams. 227 pages. Philosophical Library, New York. $3.75.

DUST OR DESTINY. By F. Alton Everest, Associate Director, Moddy Institute of Science. Illustrated by Dewitt Whistler Jayne. 96 pages. Moody Press, Chicago.

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES. Volume 54, Art. 2. Pages 143-296. May 16, 1951. "Papain" by M. L. Tainter and twelve other authors. 154 pages, illustrated. $3.00.

BETTER NURSING — A study of Nursing Care and Education in Washington. By Jean A. Curran and Helen L. Bunge. University of Washington Press, Seattle, 1951. $3.00.

HOPE AND HELP FOR THE ALCOHOLIC. By Harold W. Lovell, M. D., 215 pages. Doubleday & Company, Inc., New York 22. $2.75.

SCOLIOSIS — Pathology, Etiology, and Treatment. By Samuel Kleinberg, M. D., Attending Orthopaedic Surgeon, Hospital for Joint Diseases. 286 pages. The Williams & Wilkins Company, 1951. $7.50.

CLINICAL TROPICAL MEDICINE. R. B. H. Gradwohl, M. D., Editor-in-Chief. Luis Benitez Soto, M. D. and

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Oscar Felsenfeld, M. D., Editors. 1647 pages, with 473 illustrations, and 6 color plates. The C. V. Mosby Company, St. Louis, 1951. $22.50.

ANATOMY IN SURGERY. By Philip Thorek, M. D., F. A. C. S., F. I. C. S., Assistant Clinical Professor of Surgery (Formerly Assigned to Gross and Topographic Anatomy), University of Illinois College of Medicine. 970 pages, over 700 illustrations, more than 200 in color, drawn under the direction of the author by Carl T. Linden, Instructor in Medical Illustration, University of Illinois College of Medicine, Chicago. J. B. Lippincott Company, Philadelphia, London, Montreal. $22.50.

THE PHARMACOLOGIC PRINCIPLES OF MEDICAL PRACTICE. A textbook on Pharmacology and Therapeutics for Medical Students, Physicians, and the Members of the Professions Allied to Medicine. By John C. Krantz, Jr., Professor of Pharmacology, School of Medicine, University of Maryland, Secretary of the General Committee of Revision of the United States Pharmacopeia, 1940-50, and C. Jelleff Carr, Associate Professor of Pharmacology, School of Medicine, University of Maryland, Auxiliary Member of the Revision Committee of the United States Pharmacopeia 1940-50. Second Edition. 1116 pages. The Williams & Wilkins Company, Baltimore, 1951. $10.00.

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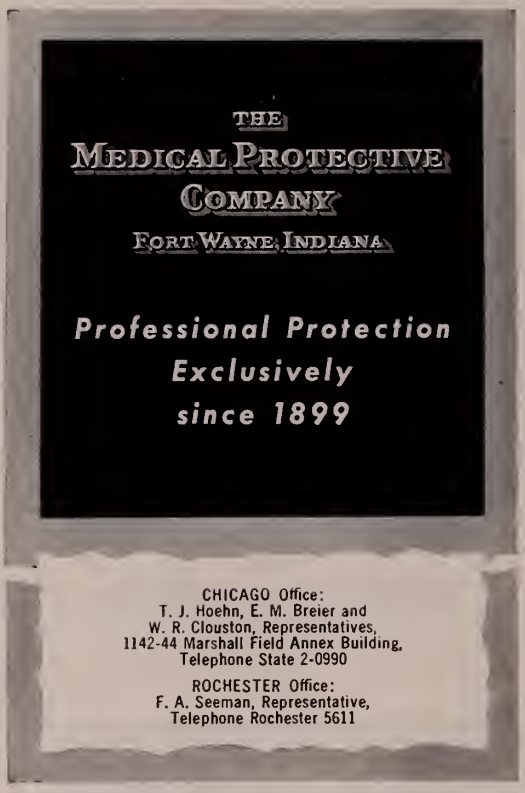
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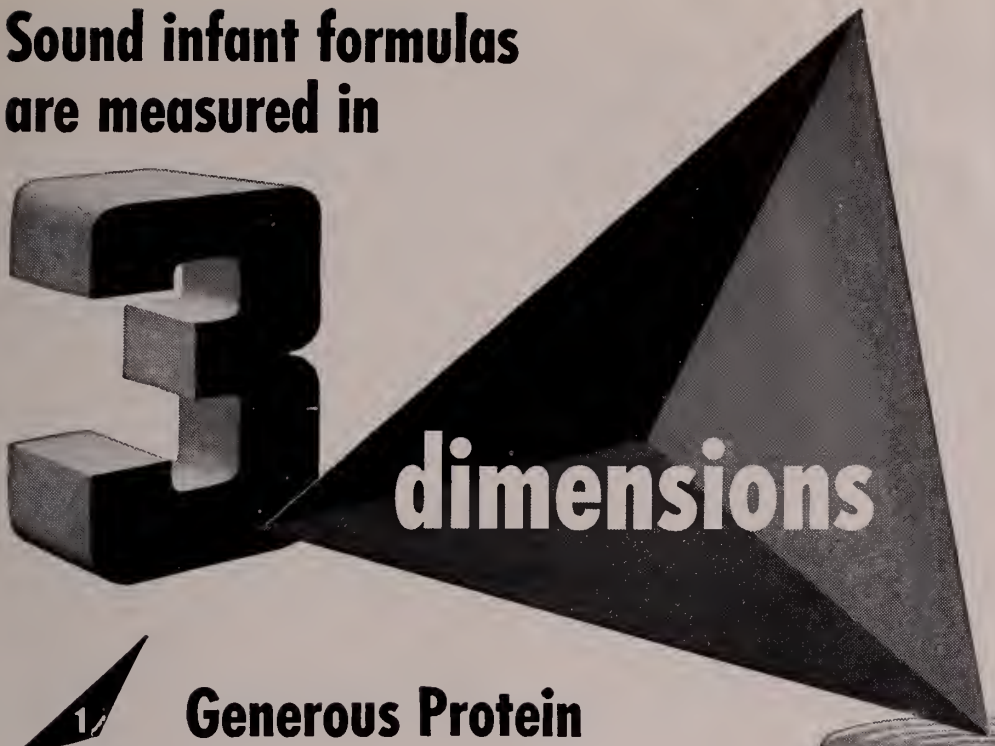
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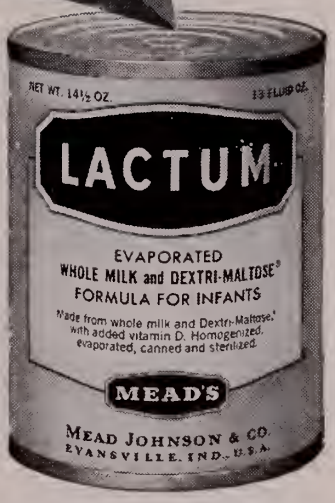
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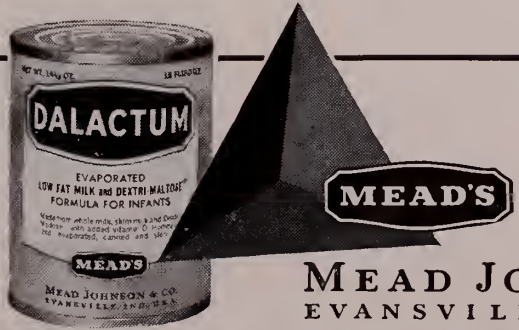
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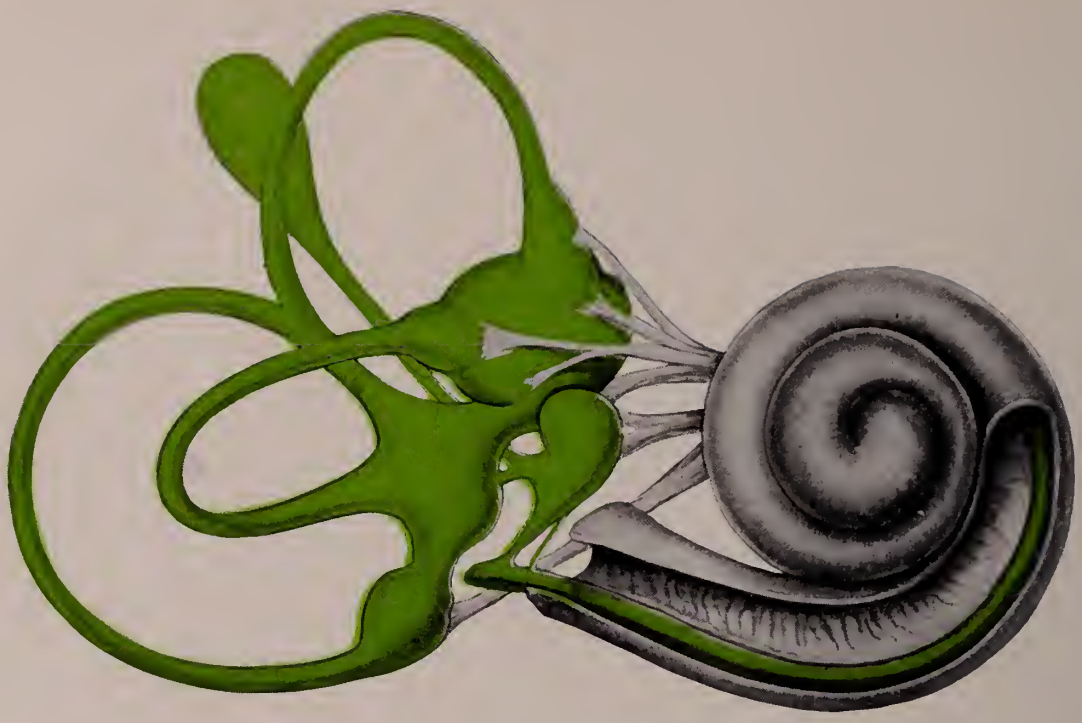
September, 1951

Citizenship Responsibilities of Medical Men

Unipolar Electrocardiography and the General Practitioner

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OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY



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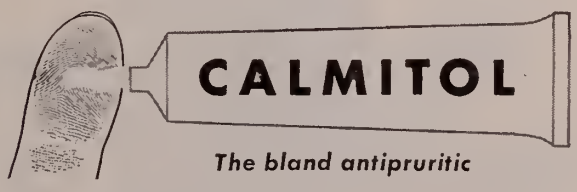
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1 Goodman, Hermon: J.A.M.A. 129:707, 1945.
2. Lubowe, I. I.: New York State Journal of Medicine 50:1743, 1950.
3. Underwood, G. B., Goul, L. E., Collins, E., and Mosby, M.: J.A.M.A. 130:249, 1946.

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1. Friedlaender, S. and Friedlaender, A. S.: Am. Pract. 2:643, 1948

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1. Stritzler, C.; Fishman, I. M., and Laurens, S.: *Transactions New York Acad. Sc., 13*:31, Nov., 1950.

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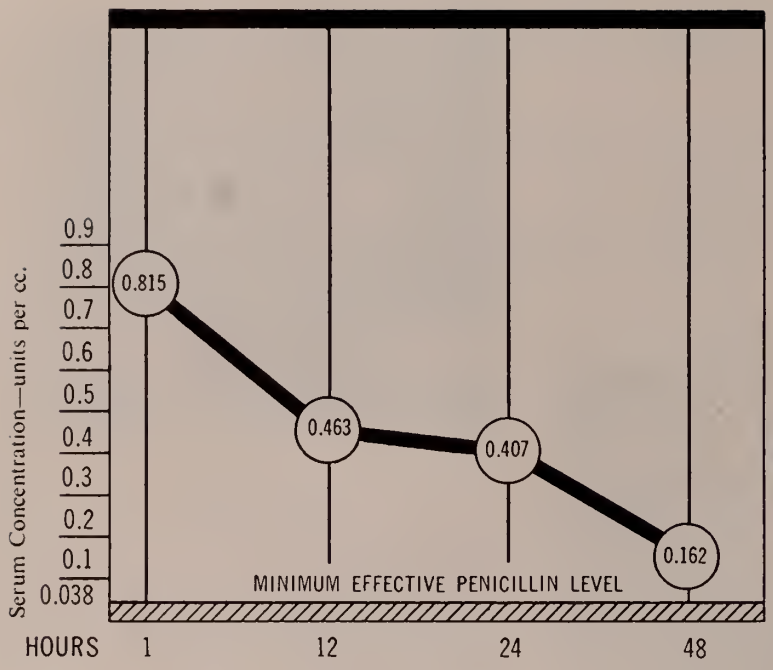
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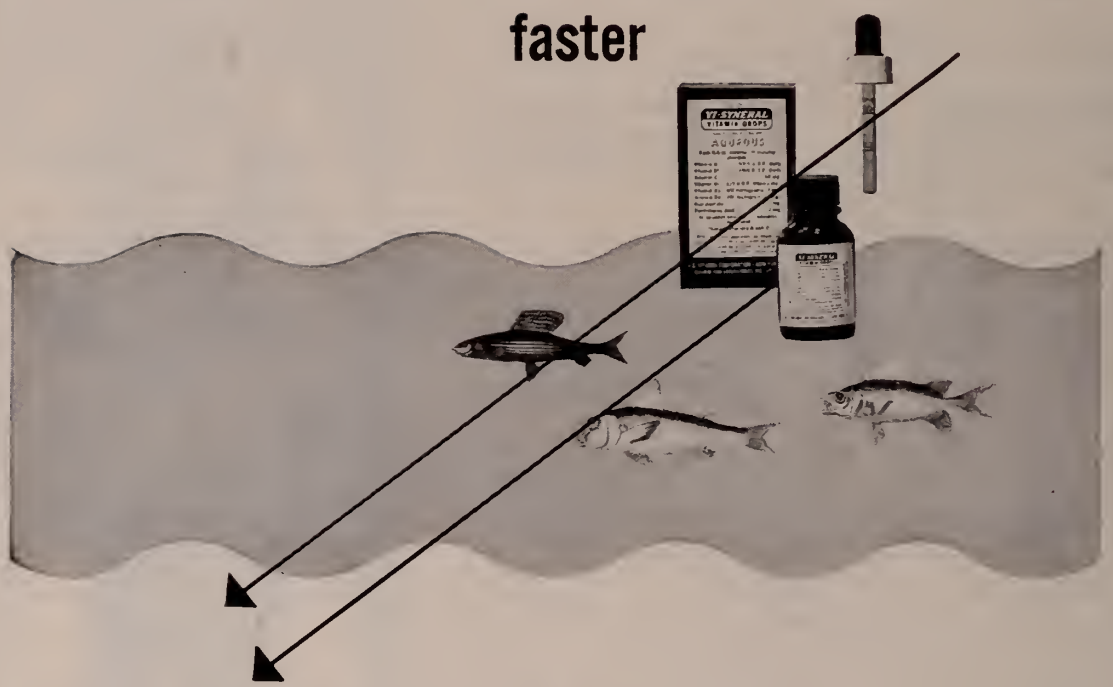
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1. Modern Concept of Allergy and Drugs Used in Its Control. *Med. Times*, 75:256, Sept., 1947.
2. Lands, A.M., Hoppe, J.O., Siegmund, O.H., and Luduena, F.P.: *Jour. Pharmacol. & Exper. Therap.*, 95:45, Jan., 1949.
3. Luduena, F.P., and Ananenko, E.: *Jour. Allergy*, 20:434, Nov., 1949.
4. Clinical investigations (unpublished) reported to Department of Medical Research, Winthrop-Stearns Inc.

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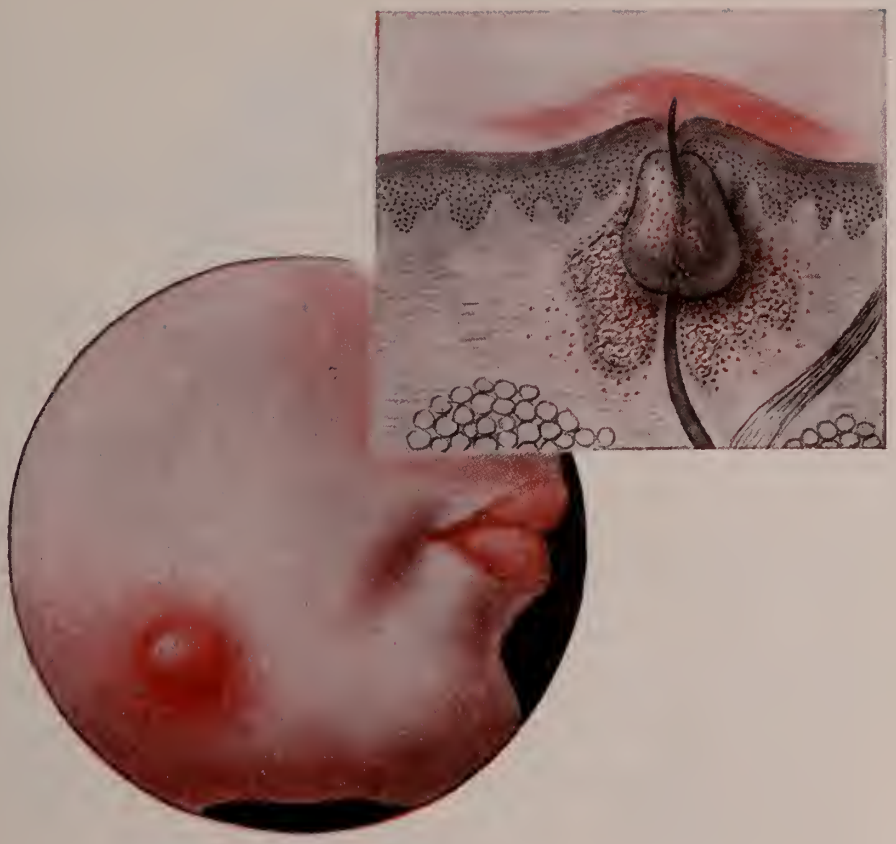
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Wright, L. T., et al: Antibiotics and Chemotherapy 1:165 (June) 1951.

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rapid and prolonged vasoconstriction

Potent bacteriostasis—Par-Pen provides 5000 units of penicillin per cc. It is therefore a potent weapon against the many penicillin susceptible bacteria which frequently initiate colds, and which almost invariably prolong and intensify colds of primarily virus origin.

Rapid and prolonged vasoconstriction—'Paredrine' Hydrobromide produces shrinkage approximately twice as rapidly as ephedrine and nearly three times as lasting. *The nasal passages are opened so that the penicillin can "get through" to the infected areas.* ('Paredrine' does *not* produce ephedrine-like central nervous side effects; and, unlike many vasoconstrictors, does *not* break down penicillin.)

Smith, Kline & French Laboratories, Philadelphia

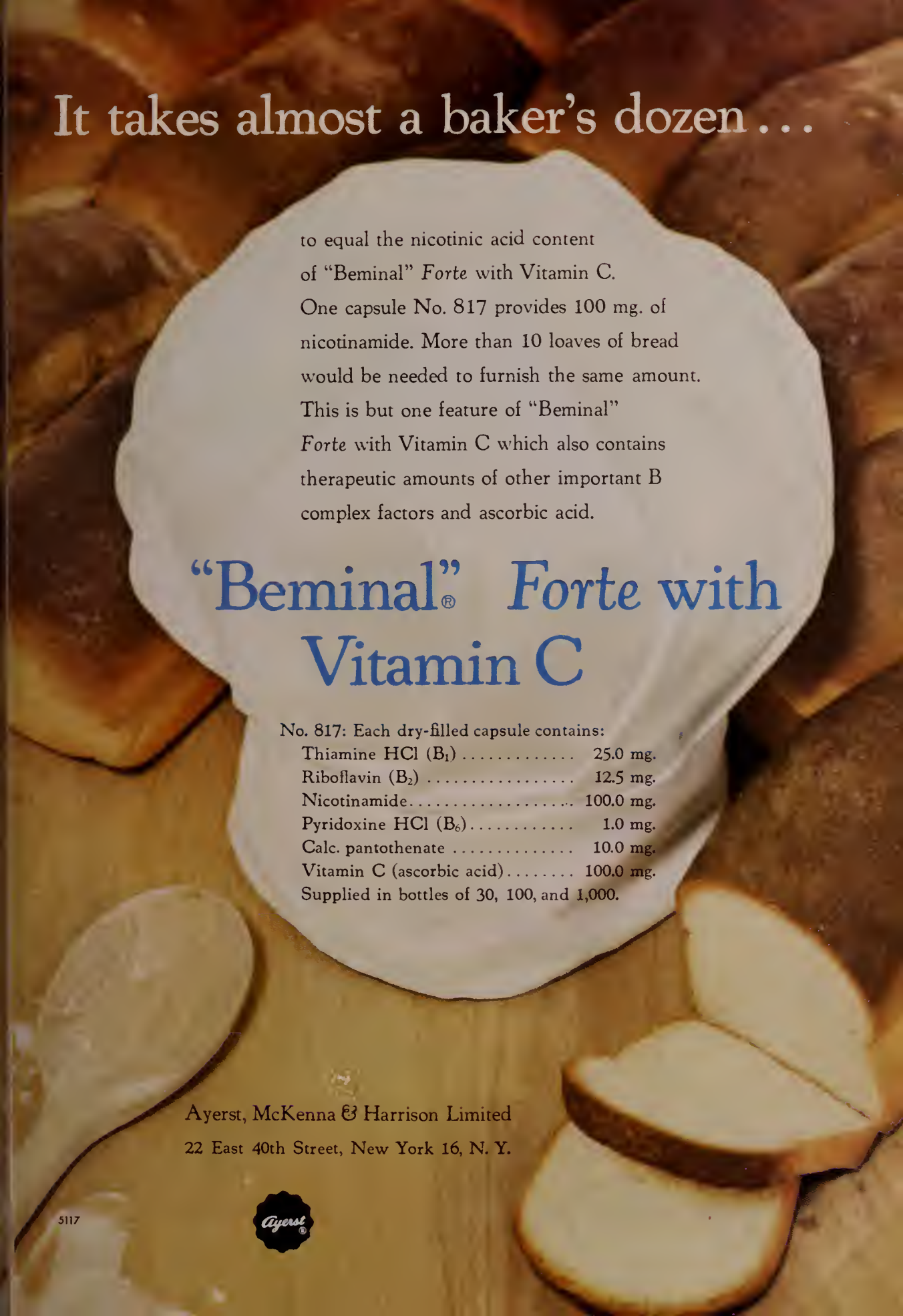
Par-Pen

The penicillin-vasoconstrictor combination for intranasal use



Formula: Par-Pen contains crystalline potassium penicillin G, 5000 units per cc.; 'Paredrine' Hydrobromide, N.N.R., 1%; in a specially buffered isotonic aqueous solution. Packaged in ½ fl. oz. bottles.

'Paredrine' and 'Par-Pen' T.M. Reg. U.S. Pat. Off.


It takes almost a baker's dozen...
to equal the nicotinic acid content
of "Beminal" *Forte* with Vitamin C.
One capsule No. 817 provides 100 mg. of
nicotinamide. More than 10 loaves of bread
would be needed to furnish the same amount.
This is but one feature of "Beminal"
Forte with Vitamin C which also contains
therapeutic amounts of other important B
complex factors and ascorbic acid.
"Beminal"® *Forte* with Vitamin C
No. 817: Each dry-filled capsule contains:
Thiamine HCl (B_1) 25.0 mg.
Riboflavin (B_2) 12.5 mg.
Nicotinamide 100.0 mg.
Pyridoxine HCl (B_6) 1.0 mg.
Calc. pantothenate 10.0 mg.
Vitamin C (ascorbic acid) 100.0 mg.
Supplied in bottles of 30, 100, and 1,000.
Ayerst, McKenna & Harrison Limited
22 East 40th Street, New York 16, N. Y.
5117
Ayerst®



Duo...

for complementary effects wherever combined estrogen-androgen therapy is indicated...

e. g. *In fractures and osteoporosis in either sex to promote bone development, tissue growth, and repair.*

e. g. *In the female climacteric in certain selected cases.*

e. g. *In dysmenorrhea in an attempt to suppress ovulation on the basis that anovulatory bleeding is usually painless.*

e. g. *In the male climacteric to reduce follicle-stimulating hormone levels.*

"PREMARIN"® *with* METHYLTESTOSTERONE

is designed to permit utilization of both the complementary and the neutralizing effects of estrogen and androgen when administered concomitantly. Thus certain properties of either sex hormone may be employed in the opposite sex with a minimum of side effects.

Availability: Each tablet provides estrogens in their naturally occurring, water-soluble, conjugated form expressed as sodium estrone sulfate, together with methyltestosterone.

No. **879**—Conjugated estrogens equine ("Premarin") 1.25 mg.
Methyltestosterone 10.0 mg.
Bottles of 100 tablets (yellow)

No. **878**—Conjugated estrogens equine ("Premarin") 0.625 mg.
Methyltestosterone 5.0 mg.
Bottles of 100 tablets (red)

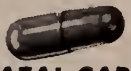


Ayerst, McKenna & Harrison Limited • 22 East 40th Street, New York 16, New York



Waterlogged peripheral tissues impede normal blood flow. Physicians have found THEODIATAL* CAPSULES reliable in providing ● Mild but prolonged diuretic action to drain the peripheral water excess ● Direct stimulation of the myocardium to greater efficiency ● Dilatation of the peripheral vessels and relaxation of the coronary vessels ● Specific bronchodilating effect to relieve Cheyne-Stokes respiration ● Gentle sedation, allaying mental distress.

SUPPLIED: In bottles of 30, 125, 500, and 1,000 capsules.



Each THEODIATAL CAPSULE contains:

Phenobarbital	30	mg. (0.5 gr.)
WARNING: May be habit forming		
Theobromine	66	mg. (1.1 gr.)
Sodium Theobromine	0.13	Gm. (2.2 gr.)
Potassium Iodide	60	mg. (1.0 gr.)
Sodium Salicylate	0.11	Gm. (1.7 gr.)

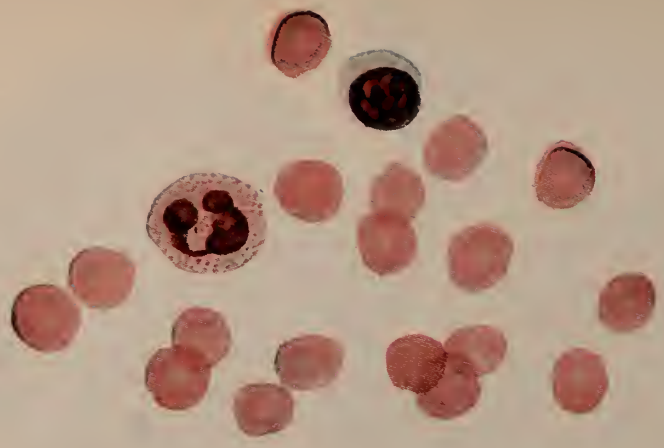
Theodiatal

TRADEMARK

C A P S U L E S

E. E. KUNZE, INC., MILWAUKEE 4, WISCONSIN

*Exclusive trademark of E. E. Kunze, Inc.



8 substances



Structural and functional integrity of the normal erythrocyte depends on a wide range of substances—8 of which are encompassed in each Cebetinic* tablet:

Ferrous Gluconate	5.0 grains
Vitamin B_{12} Factors *(as determined by microbiological assay)*	1.0 microgram
Folic Acid	0.67 milligram
Thiamine Hydrochloride	2.0 milligrams
Riboflavin	2.0 milligrams
Pyridoxine Hydrochloride	0.5 milligram
Nicotinamide	10.0 milligrams
Ascorbic Acid	25.0 milligrams

For anorexia, asthenia and anemia related to: nutritional deficits; post-infection and post-surgical states; chronic blood loss; gastro-intestinal disorders of absorption; periods of rapid growth in children; puberty and pregnancy—

℞ Cebetinic

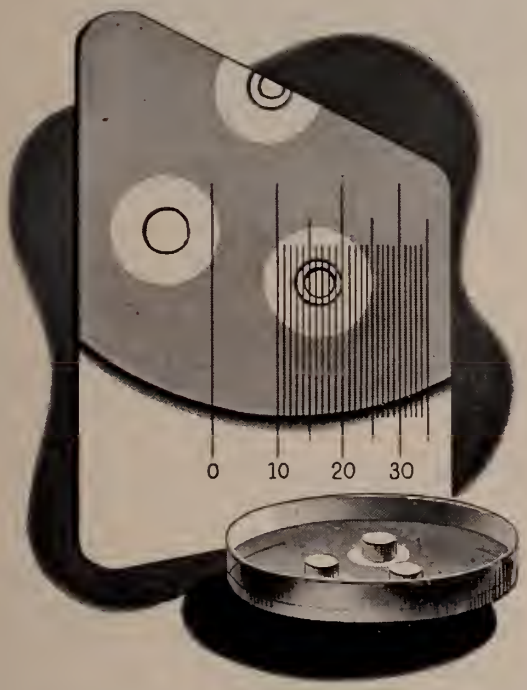
Dosage: AVERAGE ADULT — 3 tablets daily
CHILDREN—from 1 to 3 tablets daily, according to age
In bottles of 60 and 500 tablets

*Trademark

Upjohn *Medicine . . . Produced with care . . . Designed for health*

THE UPJOHN COMPANY KALAMAZOO MICHIGAN

Penicillin



Comes Close to Being the "IDEAL" ANTIBIOTIC[1]

HIGHLY EFFECTIVE

In general, ". . . penicillin continues to be the antibiotic of choice for . . . all gram-positive infections due to staphylococci, hemolytic streptococci, pneumococci . . . all cases of gonorrhea and syphilis."[2]

MINIMAL TOXICITY

"Penicillin remains a pharmacologic curiosity because of its almost completely innocuous character. No toxic effects of the dose-related type have been reported; this is the more remarkable in view of the enormous number of persons (literally millions) who have received the drug."[3]

MOST ECONOMICAL

"Penicillin, relatively inexpensive and of low toxicity . . ." ". . . in aqueous solution . . . is cheap and rapid acting . . ." "Procaine penicillin . . . in aqueous suspension . . . most economical for routine hospital use."[4]

A complete line of soluble and repository Penicillin Products is available under the Merck label.

MERCK PENICILLIN PRODUCTS

1. Pratt, R. and Dufrenoy, J., *Antibiotics*, J. B. Lippincott Company, Philadelphia, 1949, p. 30.
2. Keefer, C. S., *Postgraduate Medicine* 9: 101, Feb. 1951.
3. Goldstein, A.: Antibacterial chemotherapy, *N. England J. Med.* 240: 137-147, Jan. 27, 1949.
4. Flippin, H. F. and Israel, H. L., *Mod. Med.* p. 69, Feb. 15, 1951

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited — Montreal



OMNI-VITA* Spherettes

for supplemental and prophylactic use

For many years, much time and effort has been given to the development of an effective multivitamin preparation which would not frighten or repel the patient by its size, disagreeable taste or odor, and unpleasant appearance. The stability of OMNI-VITA* Spherettes is assured by layering of the vitamin components. Younger patients and finicky adults, particularly, were likely to object strenuously to the average multivitamin preparation—oils, liquids, tablets, or capsules.

Warner is proud, therefore, to present OMNI-VITA* Spherettes. A delicious, chewable Spherette containing generous amounts of the vitamins—an excellent and extremely convenient means for supplying either supplemental or prophylactic doses of the vitamins most frequently low in the modern diet or involved in subclinical deficiencies.

OMNI-VITA* Spherettes have a full and balanced complement of vitamins. Each Spherette contains:

Vitamin A, Synthetic . . .	5,000 U.S.P. Units
Vitamin D (Activated Ergosterol)	1,000 U.S.P. Units
Vitamin C (Ascorbic Acid)	50.0 mgs.
Vitamin B_1 (Thiamine Hydrochloride) .	1.0 mg.
Vitamin B_2 (Riboflavin)	2.0 mgs.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.5 mg.
Vitamin B_{12}, Crystalline	1.0 mcg.
Panthenol (equiv. to 1.15 mgs. d-Calcium Pantothenate) . . .	1.0 mg.

The supplemental or prophylactic use of OMNI-VITA* Spherettes ensures the the patient's cooperation—children and adults alike.

WILLIAM R. WARNER Division of Warner-Hudnut, Inc.

New York Los Angeles St. Louis

*Trademark

- *wide spectrum of antibacterial action*
- *additive and possibly synergistic antibacterial potency*
- *markedly greater safety in systemic sulfonamide therapy*
- *apparent reduction in hypersensitive reactions*
- *less possibility of development of drug-resistant organisms*

White's

Dramcillin with Triple Sulfonamides



Excellent flavor, convenience and economy for the patient.

Each teaspoonful (5 cc.) supplies:

100,000 units buffered penicillin G potassium

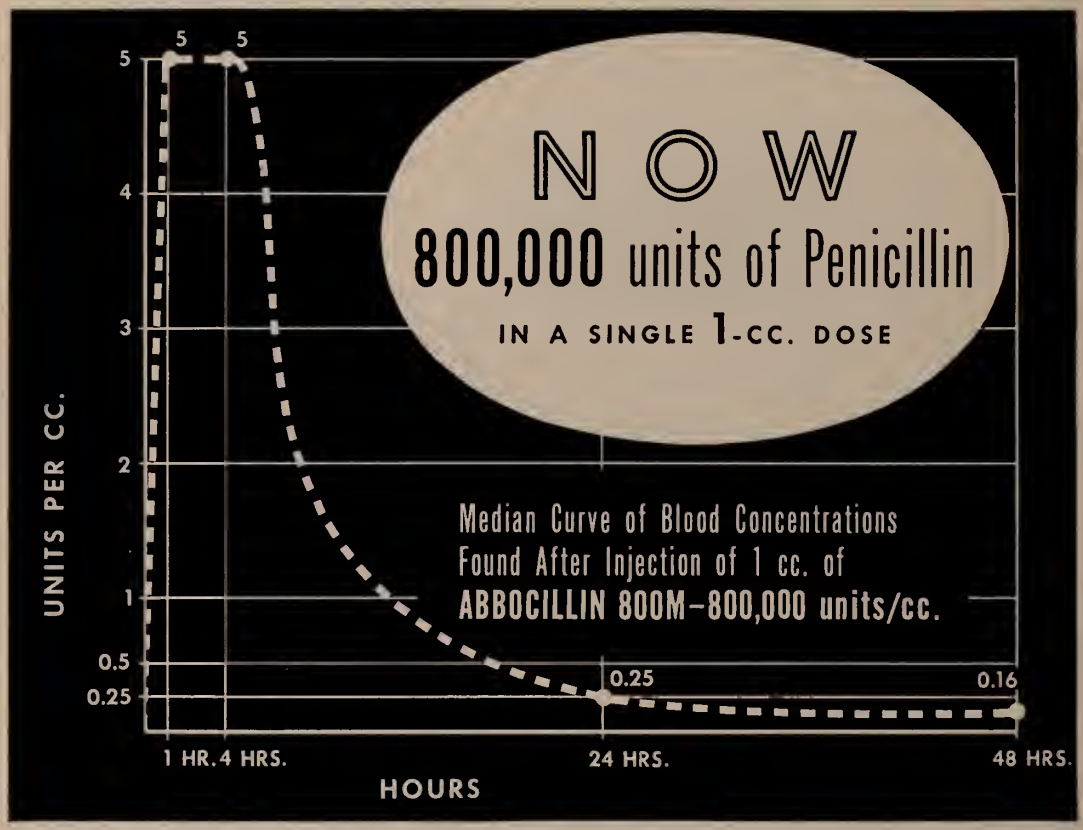
.167 Gm. Sulfadiazine

.167 Gm. Sulfamerazine

.167 Gm. Sulfacetimide—the sulfonamide of choice for the third component.

ALSO: White's Dramcillin • White's Dropcillin • White's Dramcillin-250

WHITE LABORATORIES, INC., Kenilworth, N. J.



provides both high initial peak and 48-hour repository action

THIS is truly a *high potency* penicillin product.

Combining 600,000 units of penicillin G procaine and 200,000 units of penicillin G potassium in a 1-cc. dose, ABBOCILLIN 800M offers the advantage of producing (1) a very high level of penicillin in the blood shortly after injection, and (2) a repository effect capable of maintaining effective levels for 48 hours.

As a result, ordinary penicillin-susceptible infections—such as mild to moderately severe staphylococcic and streptococcic infections and pneumococcic pneumonia without bacteremia—respond to a treatment schedule of only 1 cc. every 48 hours. In the treatment of gonorrhea and gonococcic urethritis, one 0.5-cc. injection is usually sufficient for cure.

ABBOCILLIN 800M

REG U S PAT. OFF.

PENICILLIN G PROCAINE and
BUFFERED PENICILLIN G POTASSIUM
for AQUEOUS INJECTION, ABBOTT
800,000 UNITS PER CC.

ABBOCILLIN 800M is indicated wherever repository penicillin is effective, especially when less frequent injections are desired. And its high concentration makes it economical to administer from a penicillin unitage standpoint. Supplied in 1-cc. and 5-cc. vials, singly and in boxes of 5 vials.

Abbott

enzyme-vitamin team

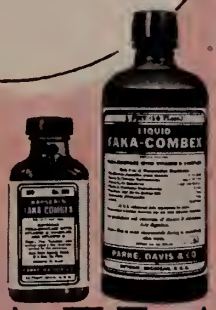


The dual action of TAKA-COMBEX® is especially useful when vitamin requirements and caloric needs are high—in illness and convalescence, pregnancy and lactation, in the very young and the very old.

It provides a combined digestive aid and nutritional supplement in convenient Liquid or Kapseal® form.

The vitamins in TAKA-COMBEX assure your patients adequate intake of important factors of the B complex (vitamin C also, in the Kapseals). In addition, the B vitamins assist carbohydrate metabolism.

The enzyme, Taka-Diastase,® one of the most potent starch digestants known, also enhances absorption of vitamin B.



TAKA-COMBEX Liquid Kapseals

TAKA-COMBEX Kapseals

Each Kapseal contains:

Taka-Diastase (*Aspergillus oryzae* enzymes)	2½ gr.
Vitamin B_1 (Thiamine Hydrochloride)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.5 mg.
Pantothenic Acid (Sodium Salt)	3 mg.
Nicotinamide (Niacinamide)	10 mg.
Vitamin C (Ascorbic Acid)	30 mg.

With other components of the Vitamin B Complex derived from liver.
In bottles of 100 and 1000.

TAKA-COMBEX Liquid

Each teaspoonful (4 cc.) contains:

Taka-Diastase (*Aspergillus oryzae* enzymes)	2½ gr.
Vitamin B_1 (Thiamine Hydrochloride)	2 mg.
Vitamin B_2 (Riboflavin)	1 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.5 mg.
Pantothenic Acid (As the Sodium Salt)	2 mg.
Nicotinamide (Niacinamide)	5 mg.

In 16 ounce bottles.

PARKE, DAVIS & COMPANY

MEDICAMENTA VERA · PD & CO.

SHIELD OF PROTECTION





IN SEVERE BRONCHIAL ASTHMA

Even when customary therapeutic measures have failed in the management of severe bronchial asthma, it is possible to block bronchial muscle spasm with ACTHAR therapy. Subjective relief may be initiated within hours; remissions with markedly improved breathing capacity and circulatory recovery may be maintained for many months. ACTHAR protects the human organism by protecting the individual cells.



IN SEVERE HAY FEVER

There are unfortunate hay fever victims who fail to respond to desensitization, antihistaminics and other customary forms of treatment. In such patients, institution of ACTHAR therapy shows great promise in relieving the harassing and frequently incapacitating symptoms, even in the presence of high pollen counts.

ACTHAR is available in vials of 10, 15, 25 and 40 I.U. (mg.). The Armour Standard of ACTHAR is now accepted as the International Unit; 1 International Unit is identical with 1 milligram of ACTHAR.

ACTHAR

THE ARMOUR LABORATORIES BRAND OF ADRENOCORTICOTROPIC HORMONE (A.C.T.H.)

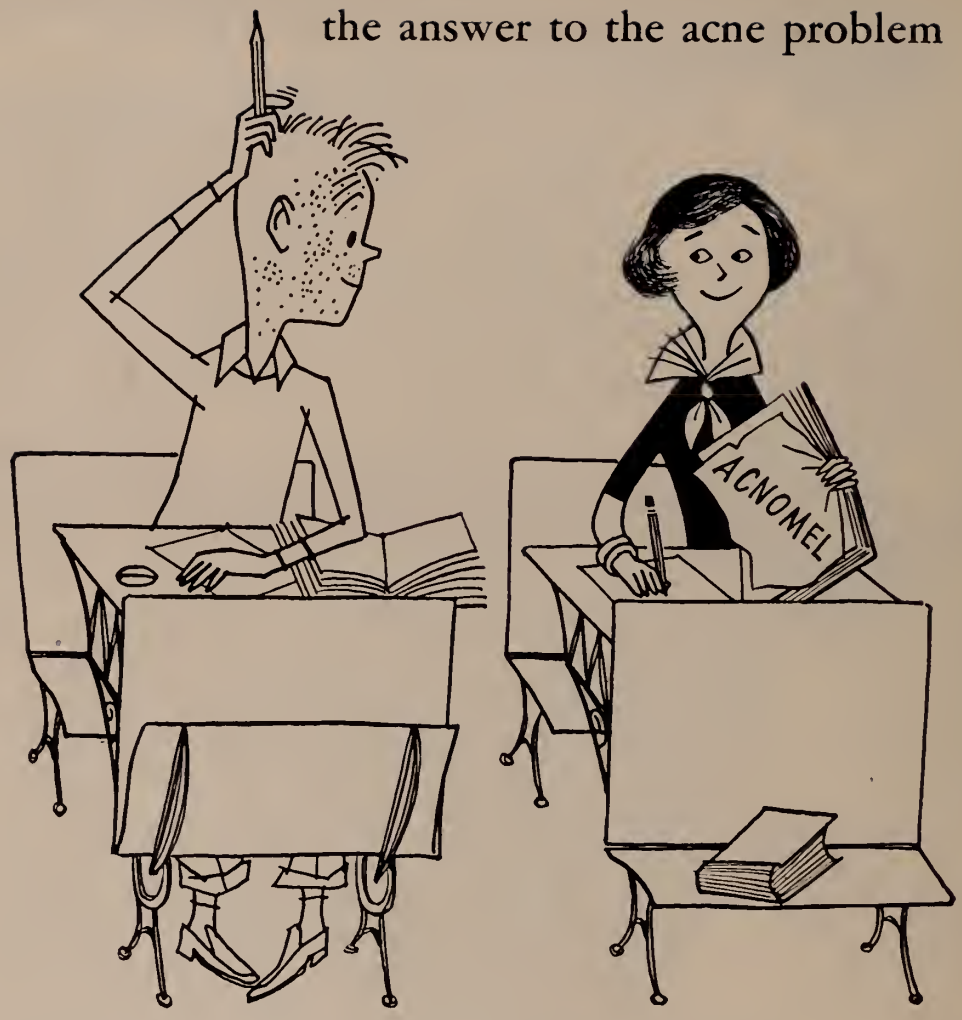
THE ARMOUR LABORATORIES

CHICAGO 11, ILLINOIS

world-wide dependability

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

the answer to the acne problem



Physicians write "Acnomel" because they know that it fills all the requirements for the successful topical treatment of acne:

1. Acnomel is rapidly effective;
2. Acnomel masks the lesions;
3. Acnomel closely matches skin color.

Acnomel is so eminently satisfactory that it is prescribed more often than all other ethical acne preparations combined.

Formula: Resorcinol, 2%; sulfur, 8%; in a stable, grease-free, flesh-tinted vehicle. Available in specially-lined 1½ oz. tubes.

Smith, Kline & French Laboratories, Philadelphia

'Acnomel' T.M. Reg. U.S. Pat. Off.

Acnomel

a significant advance, clinical and cosmetic, in acne therapy

hormones by the buccal route

Optimal utilization with minimal dosage
Effectiveness approximating parenteral therapy
Convenience of administration
Economy — cost per milligram

BUCCAL TABLETS



CORTATE®
Buccal Tablets: 2 mg.
Desoxycorticosterone
Acetate U.S.P.

ORETON®
Buccal Tablets: 2.5,
5 or 10 mg. Testosterone
Propionate U.S.P.

ORETON-M®
Buccal Tablets: 10 mg.
Methyltestosterone U.S.P.

PROGYNON®
Buccal Tablets: 0.125 or
0.25 mg. Estradiol U.S.P.

PROLUTON®
Buccal Tablets: 10 mg.
Progesterone U.S.P.

All Schering hormones
available in Buccal Tablets
are dissolved in POLYHYDROL,®
a unique *solid solvent* base.

Schering CORPORATION • BLOOMFIELD, N. J.

BUCCAL TABLETS



"bloating, belching and indigestion"

You can provide extraordinary relief of the bloating, belching and other complaints of many of your patients with so-called functional indigestion by prescribing Bilogen – a therapeutically designed choleretic-digestant. In each Bilogen tablet you'll find: Ox bile extract (2 grs.) to stimulate bile secretion, oxidized mixed ox bile acids (1¼ grs.) to flush biliary ducts, desoxycholic acid (½ gr.) to promote fat absorption, and a pancreatin of high digestive power (equivalent to 3¾ grs. Pancreatin, U. S. P.) to exert enzymatic action. Note too that this pancreatin is given double protection with a special coating to insure its release in the intestine. The coordinated action of the four Bilogen ingredients provides natural biliary stimulation, relieves upper abdominal distress, and re-establishes normal functions. Bilogen is available in bottles of 100 and 1000 tablets.

Organon INC. • ORANGE, N. J.

BILOGEN®

Organon

Effective against many
bacterial and rickettsial infections, as well as
certain protozoal and large viral diseases.

AUREOMYCIN

Hydrochloride Crystalline

Lederle

The Ophthalmologist now possesses in aureomycin a therapeutic agent effective against many infections of the eye, whether caused by bacteria or by large viruses. A half per cent solution is nonirritant to the conjunctiva, so that aureomycin may be given locally, systemically, or in both ways It has been found of value in most types of conjunctivitis, as well as in dendritic keratitis and uveitis; and is of importance in the treatment of the acute stage of trachoma. Aureomycin is invaluable in both operative and nonoperative ophthalmology.



Packages

Capsules: Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 Rockefeller Plaza, New York 20, N. Y.

No activity pause at her menopause



Your patient may continue her normal activities even to the extent of keeping pace with her daughter. She will be greatly encouraged, especially when the effectiveness of therapy measures up to expectations. In estrogen therapy an especially useful product is:

BENZESTROL

2,4 (p-hydroxyphenyl) –3–ethyl hexane

"Liver function tests, blood studies and urine examinations showed no toxic effects of the synthetic substance BENZESTROL"*

Supplied:

Oral: ***Benzestrol*** **Tablets**
0.5 Mg., 1.0 Mg., 100's & 1000's, 2 Mg., 5 Mg. — 50's — 100's — 1000's.

Benzestrol **Elixir:**
15 Mg. per fluid ounce, Pint Bottles.

Intramuscular: ***Benzestrol*** Solution in Oil; Aqueous Suspension with 5% Benzyl Alcohol 5.0 Mg. per cc. 10cc Vials.

Local: ***Benzestrol*** **Vaginal Tablets**
0.5 Mg. 100's.

AVERAGE DOSE: Menopause — 2 to 3 Mg. daily orally or ½ to 1cc parenterally every 5 days.

Schieffelin — Quality Integrity Service — ACCEPTED — Council on Pharmacy and Chemistry — American Medical Association

NOTE:
Frequently, medication other than estrogens may be required during the menopause. Pleasant tasting Elixir Benzestrol is compatible with many substances.

Professional Samples and Literature upon Request

*Reference: MacBryde, C. M., et. al., A New Synthetic Estrogen, J.A.M.A., 123: 261: 264-(10-2) 43.

Schieffelin & Co. 20 Cooper Square, New York 3, N. Y.

almost a quarter million babies annually allergic to cow's milk?



"Approximately one of every fifteen infants is allergic to cow's milk to some degree...," according to Clein in a recently published article.* These allergic reactions produce a multiplicity of strange, baffling, serious and apparently unrelated clinical syndromes.

In Clein's series of 140 distressed babies allergic to milk, "most babies were relieved of their symptoms almost immediately by discontinuing cow's milk in their formula and substituting Mull-Soy..."* These symptoms include eczema, pylorospasm, diarrhea and colic.

Mull-Soy supplies (in standard 1:1 dilution) essential protein, fat, carbohydrate and minerals comparable to those of cow's and goat's milk. The fat in Mull-Soy is soy oil, a good source of unsaturated fatty acids.

Mull-Soy is a liquid, homogenized (vacuum-packed) food—easy to take, easy to prescribe.

Available in drugstores in 15½ fl. oz. tins.

*Clein, N. W.: Cow's Milk Allergy in Infants, *Annals of Allergy*, March-April, 1951.

Mull-Soy

first in

hypoallergenic diets for infants, children and adults

The **Borden** Company, Prescription Products Division, 350 Madison Avenue, New York 17



The Postural Reflexes Remain Intact

VERILOID*

In Hypertension

A highly valuable feature of the hypotensive action of Veriloid is the maintained functioning of the postural reflexes so important to normal living. Even when the blood pressure is lowered to normal or near-normal limits, exertion and sudden changes in posture lead to the physiologic adjustments in cardiovascular dynamics, which are needed to prevent acute hypotensive episodes or collapse.

Veriloid, a distinctive, biologically assayed hypotensive fraction of Veratrum viride, finds greatest usefulness in the more severe and resistant forms of hypertension. For most patients, from 10 to 12 mg. daily in divided doses, after meals and at bedtime, are adequate, although individualization of dosage is essential for maximum therapeutic efficacy and prevention of reactions.

Veriloid is available on prescription through all pharmacies in 1, 2, and 3 mg. tablets. Literature available on request.

*Trade-Mark of Riker Laboratories, Inc.

P.S.

When side actions to plain Veriloid make administration of an adequate hypotensive dose difficult, Veriloid-VPM or Veriloid With Phenobarbital usually solves this problem. Containing Veriloid, 2 mg., phenobarbital, 15 mg., and mannitol hexanitrate, 10 mg., Veriloid-VPM is usually well tolerated in therapeutically effective dosage. Veriloid With Phenobarbital, containing Veriloid, 2 mg., and phenobarbital, 15 mg., is preferred when the action of mannitol hexanitrate is not desired.

RIKER LABORATORIES, INC.
8480 BEVERLY BLVD., LOS ANGELES 48, CALIF.



Antiquated PROTECTION

Recent nutritional investigations have established that vitamins alone are ineffective antiquated protection against dangerous nutritional deficiencies.

> ". . . lacking minerals, vitamins are useless. . . . Vitamins control the body's appropriation of minerals, and in the absence of minerals they can have no function . . ."[1]
>
> 1. Bulletin of Fla. St. Dept. of Agriculture, No. 123, pp. 20-30.

Both minerals and vitamins are essential components of the vital enzymes which control all metabolic activity.

For *true* nutritional supplementation—*dependable* protection against nutritional deficiencies—specify VITERRA—9 vitamins and 11 minerals and trace elements in a single, easy-to-take capsule.

Each Capsule Contains:

Cobalt	0.1 mg.
Copper	1 mg.
Iron	10 mg.
Iodine	0.15 mg.
Calcium	213 mg.
Manganese	1 mg.
Magnesium	6 mg.
Molybdenum	0.2 mg.
Phosphorus	165 mg.
Potassium	5 mg.
Zinc	1.2 mg.
Vitamin A	5,000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Thiamine HCl	3 mg.
Riboflavin	3 mg.
Pyridoxine HCl	0.5 mg.
Niacinamide	25 mg.
Ascorbic Acid	50 mg.
Pantothenate	5 mg.
Tocopherols, Type IV	5 mg.

Viterra is also available as *VITERRA LIQUID*, palatable, non-alcoholic, easy-to-take . . . especially suited for children and the aged.

Adequate PROTECTION



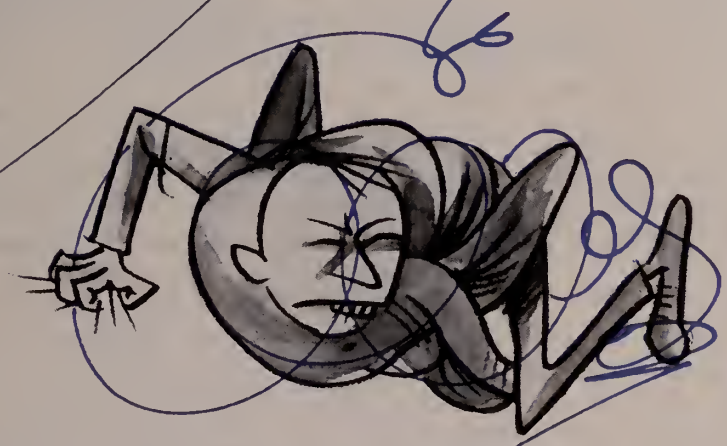
Available at prescription pharmacies . . . supplied in bottles of 100 capsules

ROERIG Rx **J. B. ROERIG AND COMPANY,** 536 LAKE SHORE DRIVE, CHICAGO 11, ILL.

Patients all wound up



with Nervous Indigestion?



NOW...*effective, comfortable, sustained relief* from pain, cramps, general discomfort due to functional gastrointestinal spasm. In clinical studies,[1, 2, 3] BENTYL gave gratifying to complete relief in 308 of 338 cases, yet was "... virtually free from undesirable side effects."[3]

BENTYL

SAFE, DOUBLE-SPASMOLYSIS

Each capsule or teaspoonful syrup contains:

BENTYL **10 mg.**
For comfortable relief of nervous indigestion

BENTYL **10 mg.**
with **PHENOBARBITAL** **15 mg.**
When synergistic sedation is desired

DOSAGE

ADULTS: 2 capsules or 2 teaspoonfuls syrup 3 times daily, before or after meals. If necessary, repeat dose at bedtime.

IN INFANT COLIC: ½ to 1 teaspoonful syrup 3 times daily before feeding.[4]

Merrell
1828

New York · CINCINNATI · Toronto

1. Hock, C. W.: J. Med. Assn. Ga. 40:22, 1951. 2. Hufford, A. R.: J. Mich. St. Med. Soc. 49:1308, 1950. 3. Chamberlin, D. T.: Gastroenterology 17:224, 1951. 4. Pakula, S. F.: To be published.

Trade-mark "Bentyl" Hydrochloride

Chemically Standardized Veratrum Viride Is Effective in Hypertension

Much has been written pro and con about the value of veratrum viride in hypertension. For many years the drug has been in disrepute because of the fact that the preparations available on the market have been prepared by "hit or miss" methods.

Chemical standardization of veratrum viride, however, has provided in this drug a highly effective agent for the treatment of hypertensive patients.

Sollmann[1] states that veratrum is probably the most active and reliable cardiac depressant and that its use serves to slow and soften the pulse and lower the blood pressure.

Willson & Smith[2] state that veratrum viride possesses a vasodilating effect and because of this, it was demonstrated by Hite,[3] and Freis and Stanton,[4] that the drug lowered pressure in hypertension and gave symptomatic relief. Recent research tends to show that the decrease in blood pressure results more from peripheral vasodilation than from depression of cardiac output.

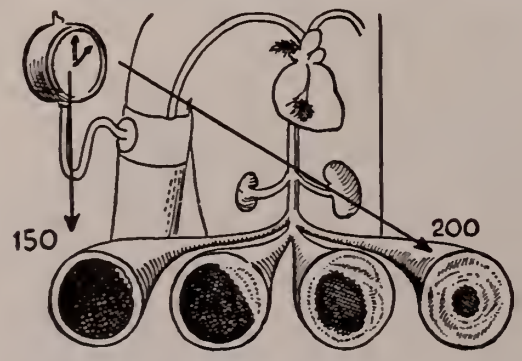
Uniformity of Action

When the veratrum alkaloids are chemically standardized, a uniform result can be expected. Their action usually causes a reflex fall in blood pressure and heart rate which originates in the afferent vagus nerve endings in the myocardium of the left ventricle and in the lungs. Although these factors ordinarily result with each heart beat, the veratrum alkaloids cause them to act continuously over prolonged periods of time. Reports have shown that 80 to 90 per cent of hypertensive patients respond to therapy when chemically standardized veratrum viride is used.

Cardio-Vascular Symptoms Cleared

In addition to the lowered pressure, objective signs of improvement may be observed, such as the clearing of retinal hemorrhages; diminution in cardiac size and reversal of left ventricular strain patterns in electrocardiograms.

Accompanying symptoms of the cardiac-hypertension syndrome, such as exertional dyspnea, tachycardia, nervous irritability, headache, are relieved. Yet, while the results of veratrum viride medication are prolonged, the drug may not afford quick relief.



Role of the Nitrites

For prompt and effective fall in blood pressure, nitroglycerin, which acts in one to two minutes, is the drug of choice. It acts rapidly and, because of its powerful vasodilatory action, gives the patient almost immediate relief. The action of nitroglycerin, however, is fleeting and to sustain lowered pressure between the action of nitroglycerin and veratrum viride, an intermediate is necessary.

To this end, sodium nitrite is used. This drug is also a vasodilator and affords sustaining relief until the long range action of chemically standardized veratrum viride becomes effective.

Importance of Sedation

Nearly all cases of hypertension require sedation for allaying periods of anxiety and affording the patient a good night's rest. Mild sedation is often useful, especially in cases associated with chronic coronary insufficiency.[5] It is well known that excitement may induce anginal attacks and in such cases, phenobarbital, because of its prolonged action, should be used.

All of these drugs, chemically standardized veratrum viride, nitroglycerin, sodium nitrite, and phenobarbital are to be found in Capsules RAY-TROTE IMPROVED, prepared by the Raymer Pharmacal Company of Philadelphia, Pa. Each capsule contains

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Sodium Nitrite	30 mg.
Nitroglycerin	0.25 mg.
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RAY-TROTE IMPROVED is effective in dosages of one capsule every three hours. It is contraindicated when renal insufficiency is present, or if pulse becomes abnormally slow following treatment.

For the 30% of hypertensive patients with capillary fault, the above formula, with 20 mg. of Rutin added, is available in RAY-TROTE with Rutin.

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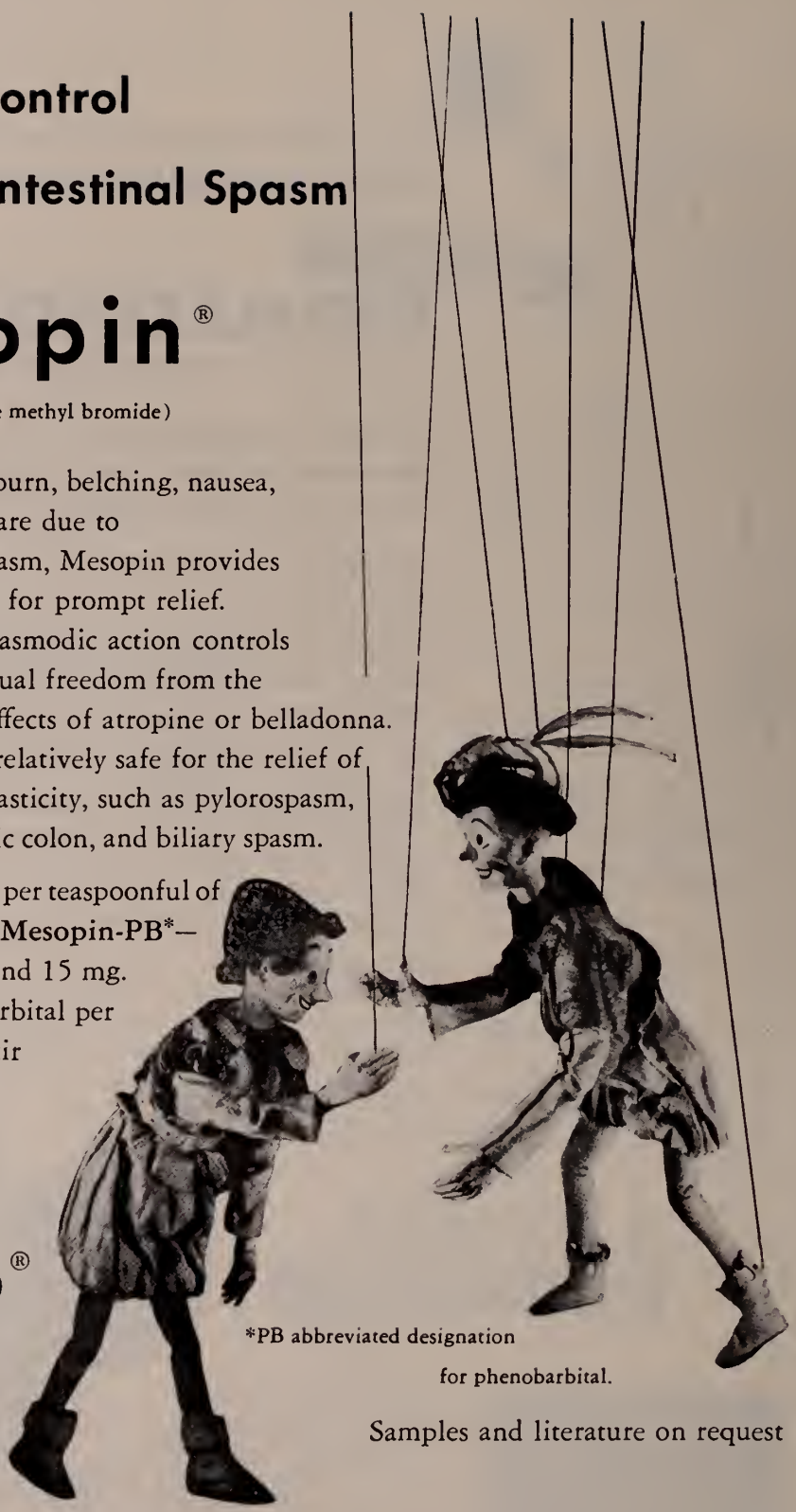
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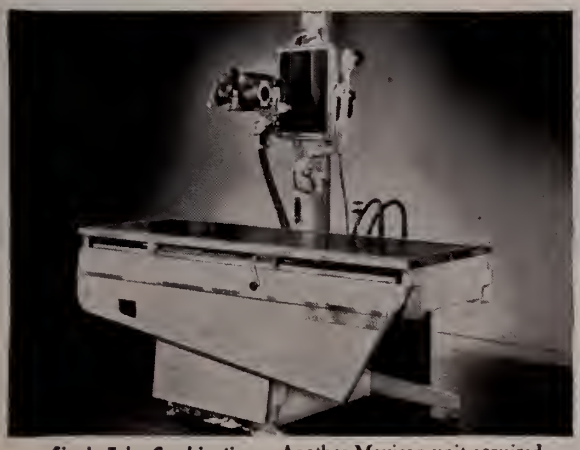
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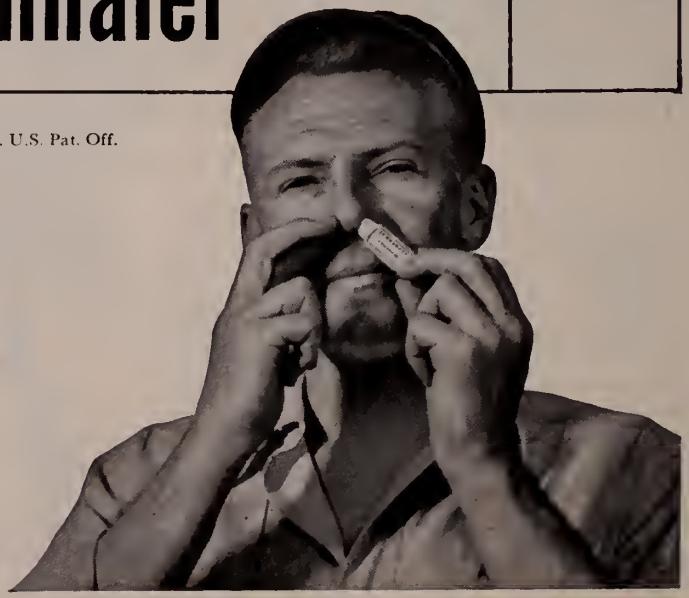
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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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PLANNING FOR EMERGENCY MEDICAL CALLS

The responsibility of providing emergency medical service for the people of this country has been assumed in most areas by the county medical societies. The various plans developed throughout the United States vary according to the population and the size of the medical society providing the service.

The Council on Medical Service of the American Medical Association has prepared a resumé of the plans of sixteen county medical societies and published the material in a booklet "Planning for Emergency Medical Calls".

The three general types of plans included in this material are: (1) Society operated telephone answering services, (2) Emergency Call services, (3) Privately operated services.

Mercer County, Pennsylvania has set up separate systems in each of the four population centers in the county at the local hospitals. Lists are kept of all physicians willing to be on "call" on weekends and holidays, nights and Wednesday afternoons. The public is informed by newspaper advertisements to call their local hospital when they are unable to contact their own physician. The hospital switch board operator gives the name and number of the physicians, in rotation, to the person calling, and the individual himself calls the physician. Each physician can go on or off the list as he desires — the service is purely voluntary.

The Cincinnati Academy of Medicine has maintained a twenty-four hour telephone service for the benefit of the public since November 1933. The charge for the telephone service on a flat rate basis, costs the Academy $33.00 a month for three independent lines. This constitutes the maximum cost of the phone service except a little extra for keys and extensions. The physicians frequently will have the line "If no answer, call the Academy of Medicine, PA 2345" under their names in both the white and yellow sections of the telephone directory. The physician pays for this printing himself, but pays nothing to the Academy for handling calls for him. Every active member of the Academy automatically is listed as a user and subscriber to the Academy's twenty-four hour telephone service without payment of anything extra.

The Medical Society of the District of Columbia has a telephone answering service which operates as a non-profit agency of the Society. The Medical Bureau offers two types of coverage — listing service and telephone secretarial service. The listing service is on the basis "If no answer, call Medical Bureau". The secretarial service consists of a private line connecting the physician's offfice or residence with the Bureau and providing complete twenty-four hour cover-

age. When the physician wishes to transfer his calls, he throws a switch on his telephone and the call is automatically transferred to the Bureau. The fee for this service is $8.00 monthly, payable every two months. In both the services there is a charge of five cents for each message over sixty per month in addition to the fee listed.

Other systems which are outlined include the setups in Cleveland, Toledo, Harrisburg, Milwaukee, San Diego, etc. Emergency call services in San Francisco, Indianapolis, Detroit, Erie and Sharon, Pa., are outlined.

Privately operated services as established in Los Angeles, and Oklahoma City, are described in detail.

Among the 16 plans perhaps the solution to your local problems can be found. The importance of emergency medical call service cannot be stressed too often. Each society, no matter how small, should work out some means to provide emergency medical care for everyone at the time it is needed, without delay and without fail. This is one of the most important phases of public relations between the physician and his patients. By solving this problem at the local level contributes materially to the public relations picture at the national level.

Has your county medical society established such a program for the residents in your area?

"DOC SCHREITER DAY"

Savanna, Illinois honored Dr. Joseph B. Schreiter on Wednesday, August 8, the day being officially designated as "Doc Schreiter Day". Dr. Schreiter, after graduating from Rush Medical College, came to Savanna to start his practice in 1896 and has practiced continuously in that city for the past 55 years. He was elected Coroner of Carroll County in 1900, which position he held for 48 consecutive years. He was commissioned as 1st Lt. in World War 1, was in France 22 months, and reached the rank of Major. He was later retired as Colonel.

Dr. Schreiter became interested in all community activities, served as city health officer, member of the Board of Education, and was chief of staff of the local hospital. He is an officer in the Savanna Savings Building and Loan Association and also of the National Bank of Savanna. During his 55 years in the practice of medicine he has officiated at the birth of more than 4,000 babies.



Dr. Andy Hall, principal speaker and Dr. and Mrs. Joseph B. Schreiter as they appeared on "Doc. Schreiter Day."

The city of Savanna and surrounding territory participated in celebrating the "Doc Schreiter Day" on Wednesday, August 8, starting with a parade in the downtown area, then a two-mile parade to the city's Old Mill Park, where the afternoon program was presented. Luncheon was served to the many invited guests and there was free coffee for all. Many of Dr. Schreiter's babies were present to pay their respects to their doctor. Among these was Wayne King, the "Waltz King", who was in the parade and appeared as a speaker in the afternoon.

For the afternoon program, Dr. Edward C. Turner, Savanna, and one of Dr. Schreiter's babies, acted as master of ceremonies. A number of distinguished guests were introduced who spoke briefly. Wayne King paid his respects to Dr. Schreiter and the medical profession in general for the fine work which has been done to alleviate human ailments, and lower mortality and morbidity rates.

C. Paul White, as President of the Illinois State Medical Society, gave the felicitations and best wishes to Dr. and Mrs. Schreiter for the Society's official delegates and the 10,000 individual members.

The principal address was given by Andy Hall, Mt. Vernon, who had been invited to come 362 miles from his home to pay his respects to the physician he had known for many years, and likewise convince a large audience that a mere 55 years of practice does not necessarily mean that a physician is on his way out. Dr. Hall, in his convincing manner, told of the many advancements in medical knowledge during recent decades, improvements in vital statistics, and what might be expected in the future, if medicine is permitted to be carried on as a private enterprise.

Business houses in Savanna were closed, so the managers and employees alike could be present to aid in honoring their number one citizen of the day. It was the general feeling as expressed by several speakers, that it is much better to honor a distinguished citizen while he is well and able to appreciate how highly his services were appreciated rather than to eulogize his memory after he is gone.

It was estimated that perhaps 3,000 people were present to hear the talks that warm afternoon, and it was quite obvious that everyone present was prompted by their high regards for the physician who has been their friend for so many years.

The Council of the Illinois State Medical Society had named the President, C. Paul White; Chairman of the Council, Charles P. Blair; Councilor for the 1st District, Joseph S. Lundholm; Vice President, J. Howard Maloney; and the Secretary-Treasurer, Harold M. Camp, as official delegates, and all of this group of officers were present.

The City of Savanna should be complimented for setting aside one day to honor a physician who had given good service over a long period of years, and who still enjoys good health. The business district was well decorated, and as it was stated in Savanna that day, everything was closed except the post office and the railroad station.

IMMUNIZATION FOR TRAVELERS

The latest facts on immunization for travelers going to every section of the world are detailed in a booklet just released by the U. S. Public Health Service. The title of the booklet is "Immunization Information for International Travel." It includes official information on the immunizations required and recommended by each country and the immunizations recommended by the Public Health Service as a precautionary measure for persons traveling abroad. Other items of importance to the traveler include an explanation of the procedure for having inoculations recorded on the International Certificate of Inoculation and Vaccination; a list of Public Health Service facilities where yellow fever inoculations can be obtained; and maps showing the yellow fever endemic areas of the world.

All changes in immunization requirements made after the publication of this booklet will be given in the weekly "Communicable Disease Summary," released by the Public Health Service, under the heading "Quarantine Measures." Travelers can obtain this information from local and State health departments.

The booklet may be purchased from the Superintendent of Documents, Government Printing Office, Washington, D. C. for 20c a copy. A twenty-five per cent discount is allowed on orders of 100 copies or more delivered to the same address.

CORRESPONDENCE



"YOUR MENTAL HOSPITALS" THE NATIONAL MENTAL HEALTH ACT

At the last legislative session a bill was passed which was signed into law designating the Illinois Department of Public Welfare as the mental health authority for the State of Illinois. As the mental health authority, the Department of Public Welfare will dispense funds which are granted to the State by federal appropriation. This year the funds will amount to approximately $160,000 and, as in the past three years, this will be expended for mental health education, outpatient psychiatric clinics, and training of psychiatric personnel. An advisory committee on National Mental Health Funds was appointed by the Illinois Department of Public Welfare, consisting of the following: Dr. Paul Hletko, Chief Medical Officer, Department of Public Welfare; Mrs. Margaret Platner, Psychiatric Social Service; Representative Bernice T. Van der Vries, Illinois Society for Mental Hygiene; Dr. David Slight, Mental Health Clinics; Dr. F. G. Norbury, Illinois State Medical Society; Dr. Donaldson F. Rawlings, Illinois Department of Public Health; Dr. Groves B. Smith, Superintendent, Beverly Farm Home and School, Godfrey, Illinois; Dr. Louis Jacobs, United States Public Health Service; Mr. Ray Graham, Director, Education of Exceptional Children, Office of Superintendent of Public Instruction; Mr. Bertram L. Smith, Institute for Juvenile Research Advisory Board.

In addition to the advisory board, a committee of consultants were appointed consisting of: Dr. Lewis Pollock, Chairman of Department of Nervous and Mental Diseases, Northwestern University Medical School; Dr. Nathaniel F. Apter, Professor of Psychiatry, The University of Chicago School of Medicine; Dr. Francis J. Gerty, Head of Department of Psychiatry, University of Illinois College of Medicine; Dr. John H. Madden, Chairman, Neuropsychiatry, Loyola University School of Medicine; Dr. H. H. Garner, Department of Nervous and Mental Diseases, Chicago Medical School.

Several meetings of the advisory committee have been held to formulate plans and consider requests for funds from various psychiatric clinics throughout the State.

In addition to the above clinics, the Illinois Department of Public Health and the Illinois Department of Public Welfare will use part of the money available for the training of qualified psychiatric social workers and other individuals in the field of mental health. A certain amount of money will also be available to foster preventative and educational activities in the field of mental health. It is hoped that by this combined approach, Illinois will forge ahead and explore new avenues in the entire field of mental health.

George A. Wiltrakis, M.D.
Deputy Director

PRESIDENT'S MESSAGE TO THE WOMAN'S AUXILIARY 1951-1952

During the Vacation Season many have tried their luck fishing, others have been mountain climbing, still others motored here and there and enjoyed themselves in their favorite forms of recreation.

Now that our Vacations are over, let us give back to humanity some of the accumulated energy in service to our Auxiliary and the Public. We want to make this a record year for our organization. I have felt for some years that we need pay more attention to Ethics. We might read and study about this for months without effect, for it's something that we must feel and live, in other words, it must come from the heart, for the basis of Ethics is courtesy; kindness; unselfishness; honesty; sincerity and justice, and no group can succeed "With flying colors" without using many, if not all of these factors. How can we attain these qualifications? By practicing them in our everyday lives; in our homes; during our shopping; riding on a crowded bus; streetcar or train; driving an automobile and in everything we do.

As we start another year may we as members realize the influence that we have in the adjustment of some of the vital problems of this ever changing world. Let us take what knowledge we have and use it. There has never been such a time as this. Let us try to have *misunderstanding* replaced with *understanding* and distrust replaced with trust. May there be no shadows; Let the candles burn brightly, leading us on.

An important point to keep in mind always is the fact that the Woman's Auxiliary, at all three levels, National, State, County, is *one* organization with one main program to follow. This program is given to us by the American Medical Association. The main fields are Public Relations, Nurse Recruitment, Legislation, Promote the sale of Today's Health, Civil Defense, Bulletin. Every member should be a subscriber, it's our "workbook".

Here in Illinois we have our own Benevolence. You have been most generous in previous years and I am hoping for a continued support. We now have our own Auxiliary news, remember this is your edition. Help us make it an outstanding publication. We will welcome suggestions. As you perhaps know the Auxiliary is increasing each year in numbers, but Growth is not in numbers alone; what have we contributed individually? A parent takes pride in the development of its child; so our Auxiliary takes pride in the development of its members. As your President for the coming year I realize fully the position which calls for courage, thoughtful choices and the will to follow through, with the kind thoughts of Auxiliary members and the ever helpful Chairmen and Officers and Councilors and the sound Council of our Advisory Committee, I will do my best to carry on, remembering always the President is a servant of all.

Mrs. James M. McDonnough, President
Woman's Auxiliary to the Illinois
State Medical Society

CLINICS FOR CRIPPLED CHILDREN LISTED FOR OCTOBER

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois Division of Services for Crippled Children. The Division will conduct 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clincians are selected among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The October clinics are:

October 3 — Joliet, Will Co. TB Sanitarium
October 3 — Alton, Alton Memorial Hospital
October 9 — Peoria, St. Francis Hospital
October 9 — E. St. Louis, St. Mary's Hospital
October 10 — Hinsdale, Hinsdale Sanitarium
October 11 — Cairo, Public Health Building
October 11 — Springfield, St. John's Hospital
October 11 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
October 12 — Chicago Heights (Rheumatic Fever), St. James Hospital
October 16 — Danville, Lake View Hospital
October 16 — Pittsfield, Illini Community Hospital

October 17 — Chicago Heights, St. James Hospital

October 18 — Rockford, St. Anthony's Hospital

October 18 — Litchfield, St. Francis Hospital

October 23 — Peoria, St. Francis Hospital

October 23 — Flora, Clay Co. Memorial Hospital

October 24 — Elgin, Sherman Hospital

October 25 — Mt. Vernon, Masonic Temple

October 25 — Normal, Brokaw Hospital

October 25 — Glenview, Village Hall

October 26 — Chicago Heights (Rheumatic Fever), St. James Hospital

October 30 — Effingham (Rheumatic Fever), Douglas Township Building

October 31 — Springfield (Cerebral Palsy), Memorial Hospital

October 31 — Aurora, Copley Hospital

MISSISSIPPI VALLEY TRUDEAU SOCIETY

The annual meeting of the Mississippi Valley Conference on Tuberculosis and the Mississippi Valley Trudeau society will be held October 4, 5, and 6 in Chicago at the Sherman hotel.

The two groups will meet jointly on Thursday for the opening of the meeting and a public health session. The subject of the Friday morning Trudeau session will be "A Study of Cases Coming to Pulmonary Resection Including Medical, Roentgenological, Surgical and Pathological Features," by Drs. J. W. Gale, A. R. Curreri, D. M. Angevine, and L. W. Paul.

At the Friday afternoon session, Dr. Sol Roy Rosenthal will speak on "Immunization with BCG," and Dr. John Skavlem will discuss "Pathogenesis of Tuberculosis." Following these, "Patient Education Regarding Tuberculosis" will be discussed by Miss Elizabeth Kennedy, R.N., Miss Lois Plaunt, R.N., and Dr. M. C. Thomas.

The final session, Saturday morning will include the following topics: "Management of the Silicotic Patient"; "Crushing Injuries of the Chest"; "The Rationale of Early Surgical Approach to Osseous Tuberculosis and Its Complications"; "Genito-Urinary Tuberculosis"; "Widening Front in the Treatment of Tuberculosis". Speakers will be: Dr. Frank Princi, Cincinnati, Ohio; Dr. N. K. Jensen, Minneapolis, Minn.; Dr. Edward T. Evans, Minneapolis, Minn.; Dr. William Baum, Ann Arbor, Michigan and Dr. James J. Waring, Denver, Colorado.

All interested physicians are invited to attend the sessions.

Dr. W. J. Bryan, Rockford is president of the Conference and Dr. D. F. Loewen, Decatur is president of the Trudeau society.

FISKE FUND PRIZE DISSERTATION

The Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announce the following subject for the prize dissertation of 1951: "The Present Status Of Adreno-Cortical Hormone Therapy — Its Uses And Limitations."

For the best dissertation a prize of $200 is offered. Dissertations must be submitted by December 2, 1951, with a motto thereon, and with it a sealed envelope bearing the same motto inscribed on the outside, with the name and address of the author within. The successful author will also agree to read his paper before the Rhode Island Medical Society at its Annual Meeting in May, 1952. Copy must be typewritten, double spaced and should not exceed 10,000 words. For further information write the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

CHICAGO MEDICAL OFFERS TWO POSTGRADUATE COURSES

The Chicago Medical Society continues its postgraduate program by offering two courses of a complementary nature during October. The first, Endocrine and Metabolic Diseases, is scheduled for the 15th to 19th and the second, Obstetrics and Gynecology, the 22nd to 26th.

The registration fee of $60 includes mid-morning and mid-afternoon refreshments, and one dinner meeting.

With an outstanding faculty, and an unusually comprehensive program, these courses will appeal to all physicians, and since each course is limited to 100 participants, early registration is advised.

A complete program may be had by writing Chicago Medical Society, 86 E. Randolph St., Chicago 1, Illinois. Checks covering registration may be sent to the same address and should be made out to the Society.

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Malony, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



The Committee Seeks Advice

During the depression years of the early '30's when the New Deal policies were initiated, each physician became acutely aware of how economic trends and government planning were effecting the practice of medicine. The development of welfare agencies within the federal government, in the state, county and city, all presented hitherto unknown problems concerning the patient-physician relationship. The trend toward specialization, the subjects of preventive medicine, industrial medicine, group practice, and the inroads made by the government into the practice of medicine were avenues of new thought to the busy doctor.

Our friend, Dr. Edwin S. Hamilton of Kankakee, was alert to these problems and envisioned the necessity of disseminating information to the doctors in the state on these vital economic problems. In 1934, the officers of the State Medical Society appointed a "Medical Economics Committee." Dr. Hamilton served as the Chairman. The purpose of this committee was to provide monthly articles on economics in this Journal. Through the untiring efforts of Dr. Hamilton, the committee served the Society well. We were kept up-to-date on the multitude of changes occurring in the economic aspect of medical practice. Dr. Hamilton continued his excellent work through most of the war years.

In 1944 Dr. Rollo K. Packard of Chicago became Chairman of the Committee. He continued the good work, and in 1945 was succeeded by Dr. Chauncey C. Maher of Chicago. Dr. Maher stimulated the committee to continue the publication of timely articles. Voluntary health insurance programs, the Beveridge report, the Wagner-Murray-Dingell bills for compulsory health insurance, the relationship of the pathologist, radiologist and anesthetist to the hospital and the patient, and many other problems of current importance were discussed in this forum.

Now a new committee has been formed and a new chairman appointed. Your new committee is greatly indebted to its predecessors for having established the tradition of preparing articles on subjects of interest to all doctors. Each physician has been aided by the fine work accomplished by former Medical Economics Committees. The responsibility to you is well recognized, and the tradition shall be carried on. Your new committee enters its activities with a humble realization of what has gone before

and a hope for a productive future. It is our desire to prepare worthy reports on subjects of interest to the physicians of Illinois. The subject of medical economics is a very broad one. Essentially anything that helps to better the care of the patient improves the economy of the patient and the doctor. We shall endeavor to discuss such matters with you. We have now under way discussions on emergency and night calls, anesthesiology as a specialty, opportunities for service in state mental institutions, country practice, group practice, women in medicine, and doctors in insurance work.

Your committee welcomes suggestions and criticisms from you. We want to help you with your economic problems. Write us, talk to us frankly and freely, and we will do our utmost to serve you well.—J.W.

The Counterpart of Hoarding

The American public has been well indoctrinated with the idea that hoarding is bad. Hoarding is now firmly associated in the American mind with the idea of profiteering. These are, however, negative ideas. It is urgent that they be supplemented by something positive. The economy of the United States has survived whatever strains it may have suffered during the flurry of buying last summer. The time is ripe for the development of a program of economizing, storing, stock-piling, provisioning, preserving, or whatever else on wishes to call the positive, constructive, and necessary counterpart to hoarding. Some aspects of this problem impinge directly on the broad subject of public health. Others, as will appear below, have an equally direct bearing on the subjects of medical economics and emergency medical service.

One of the most immediately urgent needs in the event of a large-scale disaster is water clean enough for drinking and washing. There are two reasons for this: the possibility of failure of water-pumping systems (especially in large cities and in high buildings), and the possibility of radioactive contamination of such reservoirs as Lake Michigan. Large segments of the population are scarcely aware of the fact that deprivation of water is a much more serious emergency for the human body than is deprivation of food. Every family unit should have a non-leaking, non-corroding clean, covered metal receptacle containing 48 hours' supply of water in a protected but accessible place.

A second most urgent need is an ample supply of necessary foodstuffs in accessible places. A central storehouse can hardly be called accessible when delivery systems break down, private automobiles cannot be run for lack of gasoline, and frantic people have to spend hours of time (which is at least as valuable in wartime as in peace time) waiting in line for the inspection and punching of ration cards. In this respect the government of Switzerland has set a most admirable example. Each household must be stocked with at least two months' supply of basic foods, and people who need a loan to finance this arrangement can obtain one at low rates of interest. The American government might well go further than this. Using data available to the Department of Agriculture it would be easy to release, each week, a list of those food supplies that happen to be abundant and whose purchase is advisable. These weekly statements could point out the types of foods that are most easily stored or preserved and which lend themselves most readily to the preparation of balanced diets. It is still not generally appreciated that some easily kept and valuable foods, like sugar, may be pernicious in a diet if not balanced by other food stuffs, especially those containing nitrogen. The American public, perhaps the best nourished on earth, has been inclined to feel that fussing about calories and vitamins is something for professors and over-solicitous mothers; people need to be awakened to the fact that in wartime the avitaminoses

become stark realities. For years the Department of Agriculture has printed information on subjects ranging from the best recipe for pretzels to the optimum cooking temperature for Brussels sprouts. Now, by all means, is the time to come forward with simple, concrete directions for the best foods to store and the optimum methods of storage.

Finally, there is need for instructions regarding first aid supplies in the home. The need for these has recently been emphasized by reflections on the Cocoanut Grove disaster in Boston, where the city's hospitals were found scarcely able to cope with a number of casualties that seems infinitesimal compared with the number that resulted from the single atomic explosion over Hiroshima. It is obvious that every household must contain some resources for medical self-help. The publicity given to the use of plasma, while advantageous in some respects, has built up in the popular mind a pathetically exaggerated faith in the virtues of plasma transfusion, and the mental picture engendered by a reading of newspapers and magazines is that of a blast victim gracefully waiting, with only a slightly haggard expression on his face, for the arrival of a neatly uniformed team of rescuers with a flask of plasma. It is time that this notion was offset by a reminder that the patient may not need either plasma or cigarettes so much as a drink of clean water.

Likewise a survey of first aid kits reveals a distressing predominance of useless antiseptics, cathartics, headache tablets, and proprietary remedies for stomach ache. Again, this should be corrected by emphasis on the usefulness, the supreme importance perhaps, of simple materials for dressings. Many housewives do not appreciate the fact that the domestic flatiron, whether electric or otherwise, is a remarkably efficient sterilizer, and that clean pieees of cotton or linen cloth, properly folded during and after the ironing, and properly stored, are for practical purposes sterile. Moveover, they are usable for a great variety of purposes — as swabs, pads, packs, bandages, tourniquets, slings, and coverings for less washable bedding.

There have been complaints about the apparent apathy of the American public in the present situation. This state of mind can result from preoccupation with negative ideas like that of hoarding. It can be corrected by the inculcation of positive ideas and simple plans for action. A well-planned program of provisioning for American homes will give everyone a greater feeling of security.—F.T.J.

AN OLD STORY

. . .My own belief regarding the position of the general practitioner was so ably stated by Sir William Osler nearly 50 years ago that I would like to quote his words, which are as true today as when they were written:

"It is amusing to read and hear of the passing of the family physician. There never was a time in our history in which he was so much in evidence, in which his prospects were so good or his power in the community so potent. The public has even begun to get sentimental over him! He still does the work; the consultants and the specialists do the talking and the writing, and take the fees! By the work, I mean that great mass of routine practice which brings the doctor into every household in the land and makes him, not alone the adviser, but the valued friend. He is the standard by which we are measured. What he is, we are; and the estimate of the profession in the eyes of the public is their estimate of him. A well-trained, sensible doctor is one of the most valuable assets of a community, worth today, as in Homer's time, many another man. To make him efficient is our highest ambition as teachers; to save him from evil should be our constant care as a guild." *Excerpt: Keeping Abreast of Medical Progress, Wallace M. Yater, M.D., Washington, D. C., Pa. M. J., May,* 1951.

ORIGINAL ARTICLES



Medical Men — Their Citizenship Responsibility

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In choosing this subject as the caption of my remarks this evening, I am not unmindful of the danger of being accused as a dictator, or of invading an individual's right to form his own opinions in controversial questions affecting citizenship.

Let it be understood in the very beginning that such is not my purpose, but rather am I concerned only with presenting certain historical facts and traditions, comparing these with our present day pattern of living and thinking in order to understand this modern era of government planning, and the paths toward which our various political ideologies are leading us.

I do not care one whit what political banner anyone travels under, providing they are endowed with the spirit of 1776, the Pilgrims, or the Jamestown Colony, and are desirous of maintaining our country as a place where Liberty, Justice and Free Enterprise shall rule.

Delivered before The Secretaries' Conference of the 111th Annual Meeting of the Illinois State Medical Society, Hotel Sherman, Chicago, May 22, 1951.

We constantly hear, today, that the men of our profession are being attacked as political blunderers, avaricious schemers, and jealous egotists. Even some of our colleagues say we should not enter politics. Now, in my opinion, they do not state the premise correctly. Politics should not enter Medicine any more than politics should enter the Church. But, if Medicine is going to save itself from slander and abuse, or if the Church is going to save the citizens of their various communities, they must be compelled to enter politics, a field where creative legislation spells success or failure to all opposing forces.

Let us see what has happened previously in leading nations of the world. The Roman Empire, in conquest, was strong and united. Victory once achieved, the spoils of war and slave labor created a lethargy among the people, and the ever increasing taxes weakened it until the government became an easy prey of the hordes from the North. Likewise Germany, France, and England — all great nations — finally succumbed to the fate of wars, taxes, and Bureaucracy.

War may build or it may destroy your national wealth, depending on whether you are victorious, or whether your own country is invaded. Before the last World War, Europe had a wealth in things of $900,000,000,000. Through destruction, due to war, $250,000,000,000 of that wealth was destroyed. No wonder, a Marshall Plan!

The United States was worth $205,000,000,000 at the beginning of the war (i.e., in things) and at the end, $500,000,000,000, because they built things and nothing was destroyed. Why then, the financial problem? Because, instead of receiving homage from conquered nations, we had to support and build them up. We are in that manner dissipating our own wealth.

The responsibility which rests on any nation, that becomes an outstanding world power, is indeed great. In the past, the leadership of such nations became so confused by the complexities of government, that they failed to recognize, until too late, the pitfalls which were intentionally placed by other nationals for their destruction. Today's leaders are doubly confused. Confused by enemies from within and enemies from without. They are now seeking solutions, which dictated by political expediency, will soon become insidious diseases eating at the very heart of the nation.

This confusion of men, high in political affairs, is appalling when we view it in retrospect. Such confusion reminds me of the man who decided to go downtown for a shave one morning. He did so, got into the barber's chair, the barber put an apron on him, tucked towels around his neck, and was lathering his face when suddenly a man ran into the door of the shop and cried, "Mr. Smith, Mr. Smith, your house is on fire." Like a shot, he leaped out of the chair, through the door, and down the street, spitting lather, towels falling off, and apron waving. When he had gone a couple of blocks, he suddenly stopped. "Say, what am I running for? My name isn't Smith."

We often hear it said there is no substitute for hard work. Likewise, may it be said, that, when a citizen ceases to work, he becomes a liability to his country. He may be so financially sound, that for his own interest, he does not need to produce for his own livelihood. But, a nation's economy is largely dependent on its working population. Parasites eventually kill the host.

Many people, today, mistake Liberty for License. One may have the liberty to act as he wishes, but he does not have the license to act in such manner as to harm or destroy his neighbor. He may have the liberty of free speech, but he does not have the license to destroy the fundamental principles upon which this nation was founded. A doctor has the liberty to practice his profession as he sees fit in accordance with his knowledge, but he does not have license to take a life.

Ignorance is the basis of most misunderstandings, and name me a profession in which this is more true than in the medical profession. We are maligned by the public, criticized, condemned, and blasphemed; for the most part, unjustly, because we, as a group, have labored under the impression that our profession was beyond reproach; that our ideology was like the Rotary slogan, "Service before self," but unlike Rotary, we made no effort to tell the world about it.

We now have the reputation of being against things. We, myself included, have talked long and loud against socialized medicine, osteopathy, and other cultists, and have done so before a public, which often was not too open-minded on the subject. Of course, we are opposed to those things, but instead of building up resentment in our audiences by being simply against something; is it not better that, by comparison, we tell the world more about our accomplishment, more of what we expect to accomplish. "Sugar attracts more bees than vinegar." Let us make allies of our neighbors.

To thus advertise, has always been frowned upon by medical men. We seem to think people will see our good works, and seek after them. Unfortunately, each of us has had our bad moments. Through lack of discretion on our part, we alienate certain groups in our community, and thus practices are built and limited. Rarely does the patient condemn the profession, but only the individual medico.

In our opposition to the Osteopathic Bill in our legislature, we have spent a great deal of time in pointing out the mistakes of osteopaths. While we have a century of progress in medicine to compare with a practice that to my knowledge, cannot point its finger to one thing it has accomplished to add longevity or lessen morbidity.

The basic sciences in our schools are taught by better qualified men, and in vastly superior laboratories. All branches of medicine and surgery are taught by men whose lives are devoted to the study and treatment of the branch, which they teach — as compared with the two or three medical men, which teach all branches in the osteopathic schools. A State Senator speaking to another said, "I think I will vote for that Osteopathic Bill. The M.D.'s are always opposing them, and they seem to be doing a job, and are popular." My friend asked, "Would you want them to take your gallbladder out?" "Hell no, is that what they want?" Yes, and more too. Here again we see a lack of understanding. Osteopaths can and are licensed now for the practice of osteopathy. But, because of the advancement in medicine and surgery, they are finding it desirable to broaden their field of treatment, and seek license for their inferior trained men from inferior schools to practice medicine in all its branches here in Illinois, just as they have been able to do in many other States of the Union.

To defeat vicious legislation takes *"personalized service."*

To create a favorable opinion for medicine takes *"personalized service."*

To become an active citizen takes *"personalized service."*

To show appreciation of one's citizenship is to vote in all elections.

In the beginning of this address, I spoke of the patterns of governments. Let us review them briefly. An aggressive nation conquers, grows strong, seeks to live in luxury, increases taxes, creates bureaus, regulates economy, increases national debt, subsidizes its people, becomes a socialist state, declares a dictator, and/or surrenders to some other aggressor.

Where do we fit? Certainly, at this time, we are the most powerful nation on earth, challenged by another powerful and aggressive nation, Russia. We are probably worth a half a trillion dollars. But, to maintain our position, we are spending billions of dollars not only to prepare for an eventual war, but also to help restore a sound economy to the friendly nations of Europe, which lost one-third of their entire wealth in World War II. Quoting Joe Liston, who was Donald Nelson's assistant in the War Production Board of the last war, "Many times have I heard Franklin Roosevelt state that 'the United States was through. That it would be impossible hereafter to maintain our present economy unless we were at war or preparing for war.'"

Does that statement mean anything to you? Can you not understand how, laboring under that philosophy, that we are being bombarded with such socialistic legislation as socialized medicine, Brannan Plan for farmers, Federal Aid to Education — to name a few?

What we need today is a new conception of our destiny. Men like Washington, Alexander Hamilton, Benjamin Franklin, Andrew Jackson, or Thomas Jefferson, who carved out of a rough but rugged people, a government in which freedom was the uppermost principle. Freedom for the pursuit of happiness, the pursuit of wealth, the pursuit of knowledge, and the pursuit of religion. Indeed, a country where free enterprise is the watchword. Not a country that would assure "freedom from want — from womb to the tomb," to quote Winston Churchill.

Men of Medicine, you are a part of this complex civilization, and you hold the distinction of being leaders in your respective communities. You hold the power of health in your community, and the health of a nation measures the wealth of a nation. Since the birth of Christ, it has been estimated that there has been born 40,000,000,000 people into the civilized world, and only 1,000,000,000 less than three per cent has lived in a free country. You are among that privileged few, and I ask you, is it worth fighting for?

I do not subscribe to the philosophy that we cannot maintain our economy without being at war or preparing for war, for under Paul Hoffman, the C.E.D., a non-political organization before the outbreak of the Korean war, so organized Labor and Industry that there was a peak employment of 62,000,000, and that is not bad for days of relative peace.

We hear much said about socialized medicine in England. They do not like it, but they know that it is the only answer at the present under their economy. If our wealth is ever dissipated to the same extent, we too must submit to regimentation. Even before the last national election, we heard from both political parties that a change must occur, else we may well be a ruined nation. And, if we continue in the present manner, Socialism and Statism is just as

inevitable here as it was in Germany, France, or England.

So what! you say. Well, in my opinion, there is yet time to do something. You, individually, must personally accept your responsibility as citizens, as well as doctors. You must talk, you must write, you must be informed, and you must vote.

I have stated that it matters not what your political beliefs are. Take an active part in your local politics, and see that a man worthy, and well qualified, and above all, one steeped in the traditions of American Free Enterprise, be candidate for office, from the lowest level to the highest. Then, we need not fear for our American way of life, no matter which party is successful at the polls.

In a recent election, the medical men of Illinois were really aroused, and contributed in no small measure, to the election of a man who will have not part in socializing our profession. The medical men of Florida were likewise instrumental in electing a man who is against Socialism. And, in other states, the medical men, as citizens, not as societies, were able to create a favorable public opinion against those who seemed to favor the welfare state.

It can be done if you will do your part. Someone can't write or speak for you. In union, there is strength, and in unity of effort, there will be success.

In the coming year, often referred to as an off year, there is great danger that we may rest from our citizenship responsibilities. Gentlemen, that would be fatal. We must keep ourselves informed. We must contact those in authority, who do or will hold the reins of political power, and above all, we must sell to the people the wonders of medicine, and what it promises to the health and happiness of our country. We must ever hold high, praise for our national organization, the American Medical Association; that everyone shall learn how this watchdog of American Medicine is for the safeguard of all citizens, as well as an inspiration to its members.

Let us not in the year to come, relax in our enthusiasms, for the success or failure of ours — the most important of all organizations in the world, because of their strategic position in conserving the health of the world, depends on you.

One hundred and sixty thousand doctors in the several communities hold it in their hand to develop that public opinion, which will protect us and the public from any vicious legislation that might destroy the present physician-patient relationship.

The challenge is yours. Citizenship is an individual responsibility.

BCG FAILURES

Endless controversies concerning the dangers and the effectiveness of BCG have been present in the United States for many years. The dangers of vaccination can now be considered nil. The effectiveness as an immunizing agent is still open for discussion. Failures of vaccination may be due to (1) quantitative conditions connected with the preparation of the vaccine, or (2) the lack of technique for differentiating between allergy and protective immunity. Dr. Rene J. Dubos states that it is almost certain that the immunity produced by the vaccine is the outcome of a limited but definite multiplication of the attenuated bacilli in the body of the animal undergoing immunization, chiefly in the regional lymph nodes. The degree of immunization probably reflects in a certain measure the extent of this multiplication. It is very likely, on the other hand, that the degree of multiplication depends in turn upon at least four independent factors, namely: (1) the number of living micro-organisms injected, (2) their physiological state, (3) level of attenuation (or virulence), (4) susceptibility of the immunized individual. *Excerpt: The Present Status of BCG Vaccination, E. Fenger, M.D., Oak Terrace, Minn., Minn. Med., June* 1951.

Unipolar Electrocardiography and the General Practitioner

(An Analysis of 1000 Consecutive Electrocardiograms)

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The purpose of this paper is to evaluate the place of unipolar electrocardiography in the practice of the general practitioner. Eighty-five per cent of the doctors in the United States are in general practice and it is our belief that a large majority of the work in electrocardiography is done by this group.

The literature is replete with excellent articles on the value of electrocardiography for the internist and cardiologist, but to our knowledge very few articles can be found which stress the value of electrocardiography and especially the unipolar leads to the general practitioner. One is perfectly aware that purchasing a machine does not make one an electrocardiologist but we believe that the general practitioner who is honest and is trying to do a good job feels that he must have some working knowledge of electrocardiography, and that he is striving to work this into his armamentarium the same as he would a blood count or an urinalysis. We also feel that men like Katz,[8,14] Wilson,[2,10] Burch,[15] and Winsor,[15] are attempting to bring to the average electrocardiographer, fundamental principles which will benefit him in his interpretation of a complete survey for his cardiac patients.

In the literature there are many definitions and limitations of the electrocardiograms and the statement is made that many doctors overread their tracings.[3] The purpose of this paper is to show the place and value of the unipolar electrocardiogram in the every day practice of the general practitioner. For this reason, 1000 consecutive electrocardiograms taken by unipolar and augmented unipolar extremity leads were used for analysis. We have attempted to show the following:

1. Main pathological patterns encountered.
2. Age by decades.
3. Sex.
4. Why taken in general practice
 a. Specific cardiac checkup.
 b. Routine in an over-all checkup.
 c. Referred by other doctors.
 d. Pre-operative (patients over 50 undergoing major surgery).
5. Cardiac deaths with special reference to bundle branch blocks.

During the past decade we have seen radical changes in the field of electrocardiography. As so ably stated by Pruitt,[1] one of the penalities of progress is the painful necessity of abandoning old and comfortable ideas for new conceptions which laboratory investigations bring forth. The confusion which has existed for the past twenty years has been brought more to a head during the last ten years through the work of the American Heart Association in standardizing leads, mainly the precordials. Wilson[2,13,10] and his co-workers have brought forth the belief that unipolar leads are a distinct advantage over the old bipolar leads and this has been corroborated by such outstanding men as Bayley[5], Goldberger,[11,12] Katz,[14] Burch,[15] and Winsor[15]. Burch[4] has shown that the use generally of precordial leads is governed by empiricism rather than by an appreciation and application of the present day knowledge of the processes of depolarization and repolarization. He has shown, the same as Wilson,[2,13] that the basic principles of depolarization and repolarization enable one not only to locate but to limit cardiac pathology better than a single precordial and limb lead, the use of which is still widespread.

Electrocardiographic patterns are becoming obsolete and vector analysis as shown by Ashman,[6] and Bayley[7], is becoming necessary for the proper evaluation of the electrocardiogram. It must be emphasized that the electrocardiogram is purely a record of the site of an impulse initiation and of the spread and retreat of electrical activity of

the various chambers of the heart. Infarcts can be present in the center of the ventricles and still not be shown in the electrocardiogram. To be shown they must be near the endocardial of epicardial surface[8]. As stated by Schwartz,[9] the electrocardiogram represents the result of the potential variation between recording electrodes wherever they are placed. In taking the standard limb leads, two extremities are connected to the galvanometer of the electrocardiograph machine in pairs, thus in taking lead one the right arm is connected to the negative pole and the left arm to the positive pole of the galvanometer. The right arm and the left leg and left arm and the right leg are connected similarly in taking leads two and three. The two extremities are equidistant from the heart and undergoing potential variations of equal magnitude. These leads may be considered bipolar or the result of two unipolar limb leads. They represent a compound of the potential variations of each of the two extremities.

In 1934, Wilson[2] and his associates realizing the disadvantages in employing one of the extremities as an indifferent electrode, described a new type of electrocardiographic lead in which an exploring electrode with a central terminal connected through equal resistance to the electrodes on the right arm, left arm, and left leg was employed. They were able to show that the potential in the central terminal was negligible and nearly constant throughout the cardiac cycles. This central terminal consists mainly of 5,000 ohm resistors which are connected in each lead. However, in most of the newer machines the central terminal is built in and it becomes very simple to use V-leads and more recently, the Goldberger [11,12] leads which record unipolar leads in the extremities. These leads have fifty per cent more voltage than the first unipolar leads described by Wilson. The basic principles are the same whether V or Goldberger's augmented unipolar leads are used[18]. As Goldberger[11] has pointed out, electrocardiography as routinely used may be compared to a sphygmomanometer which instead of recording the actual systolic and diastolic pressure would merely indicate the difference between them as the pulse pressure. The more extensive use of the vector and augmented unipolar leads gives one an extra yardstick not only to locate but to delineate cardiac lesions. There is actually no limit to the areas that could be evaluated by the indifferent electrode. We have found that the number of leads which consistently give us the most complete knowledge are V-1 to V-6 inclusive, routine limb-leads, Goldberger's augmented unipolar extremity leads and, depending on the transition across the precordium, V-7 and V-8. Occasionally it is necessary to go higher in the precordium to elicit high infarctions. VE and V_3R for the right precordium, posterior and posterior basal infarctions should be used.

It has been shown that the electrical potential of any part of the body surface depends upon the potential on the surface of the heart facing it; further, the magnitude of the potential of any point outside of the heart would depend upon its distance from the heart since the extremities for all practical purposes are equidistant from the heart; the potential variations exhibited by each will depend upon the potential at the portion of the heart surface facing the extremities.

From the foregoing it is clear that the position of the heart within the thorax will have a marked influence upon the ventricular deflections observed in the standard limb leads. It has been shown that the rotation of the heart upon its anteroposterior axis or long axis will produce changes in the grades of axis deviations. The diagnostic lead patterns may be altered considering the unusual rotation of the heart upon one or more of its axes; this is accomplished by changing the spatial relationship of the heart surfaces to the extremities. It is also important to note that all parts of the heart contribute to the electrocardiographic pattern observed in the standard limb leads. Therefore, one may fail to reveal small infarcts or localized lesions because the effects are over-balanced by those of the surrounding myocardium. It is readily seen that while a routine can be set up for taking tracings, the ingenuity of the electrocardiographer is often taxed in finally deciding what other areas should be explored to correctly find the existing cardiac lesion.

It is becoming more apparent that a basic knowledge of the electrocardiographic position of the heart is necessary to properly interpret electrocardiograms. According to Goldberger[20], the main positions of the heart are:

1. *The long axis of the heart may be vertical or horizontal.* This is accomplished by rotation around the anteroposterior axis of the heart.
2. *Heart may rotate around its long axis.* This can occur in two ways, clockwise when the right ventricle becomes more anteriorly and the left ventricle more posteriorly and counterclockwise in which the exact opposite occurs.
3. *The apex of the heart can rotate forward or backward on the transverse axis.*

It can be seen that the electrocardiographic positions of the heart are essential in order to know whether special leads are necessary. For example, if the heart is vertical with marked clockwise rotation and transition to the right, and the left precordial area is being specifically scrutinized, it will be necessary probably to use V-7 and V-8. A working knowledge of this principle will lead to more focal pointing of the precordium and the finding of lesions that have been missed previously.

Main Pathological Types. For simplicity in determining the main pathological types, it was decided to divide 1000 tracings into six classifications (Table 1A). Each of the five pathological groups was further subdivided as shown in Table 1B. It is admitted that the division into six classifications is far from complete but certainly this grouping will include 98 per cent of the tracings taken in general work. The criteria used are those of Wilson, Goldberger and other exponents of unipolar cardiography. It is seen that there is an overlapping of approximately 100 due to the fact that where, for example, hypertrophy and coronary disease were present both were listed. We were surprised to find that over half of our tracings were normal. This is best explained by Table 1A where it is seen that over 50 per cent of the electrocardiograms were taken on those patients who were seen in a routine check-up. In the arrhythmias, sinus tachycardia and bradycardia were included but not sinus arrhythmias. Less than 20 per cent were in the coronary group although it is commonly felt that most tracings are taken for coronary disease. The myocardial group is a weak group as the criteria here is still debatable by many men. Slurring of all complexes with low voltage, Q-T prolongation, and abnormal forms with focal abnormalities (abnormalities limited to one lead) were of use in defining this group. Left and right ventricular hypertrophy as well as strain was a prominent classification. Left and right axis dexiation were excluded. Here the criteria of Ungerlieder and Gubner[17], Myers et al[19], Sokolow and Lyon[16] were used. Twenty per cent were in this group. Sixty heart blocks were present. The percentage of bundle branch block in the dead survey will be discussed more thoroughly.

TABLE 1A
MAIN PATHOLOGICAL TYPES

Normal	507
Coronary	185
Arrhythmias	125
Blocks	60
Hypertrophy	178
Myocardial Damage	73
	1128

TABLE 1B
MAIN PATHOLOGICAL DIVISIONS

I. Coronary Disease
 a. Occlusion (with and without infarction)
 b. Chronic coronary insufficiency
 c. Transitory coronary insufficiency
II. Heart Block
 a. Prolonged AV conduction
 b. Incomplete AV block
 c. Complete AV block
 d. Intraventricular block
 1. Right bundle branch
 2. Left bundle branch
III. Arrhythmias
 a. Extrasystoles
 1. Nodal, ventricular, auricular
 b. Tachycardia and bradycardia (sinus)
 Supraventricular tachycardias and ventricular tachycardias
 c. Auricular fibrillation and flutter (combined, and pure and impure types)
 d. Nodal escapes and rhythm
 e. Interference and dissociation
IV. Left and Right Ventricular Hypertrophy and Strain Patterns
V. Myocardial Involvement
 a. Auricular
 b. Ventricular
 c. Pericarditis
 1. Acute
 2. Chronic

Incidence According to Age. The majority of tracings were taken as one would expect between the fourth and seventh decades (Table 2). It is in this span of life that coronary disease is

TABLE 2
INCIDENCE ACCORDING TO AGE

0-10 Years	14
10-20 Years	26
20-30 Years	35
30-40 Years	98
40-50 Years	167
50-60 Years	300
60-70 Years	226
70-80 Years	119
80-90 Years	15
	1000

most prevalent; and that changes of hypertension are seen in the myocardium. It is interesting to note that 40 tracings were taken under twenty years of age. In our analysis most of these were taken in rheumatic hearts. It should be explained why 119 tracings were taken in patients over seventy years of age and fifteen in those over eighty. We have felt for years that in patients over fifty years of age undergoing major surgery a tracing should be taken routinely to properly evaluate the myocardium and coronary tree. Many of these 119 tracings were taken in patients with fractured hips and in men undergoing prostatic surgery. It is true that the findings of a bundle branch block or severe coronary disease does not deter us from doing surgery since it is usually non-elective surgery. However, we felt that the patient could be handled best from the surgeon's as well as the anesthetist's standpoint, if a tracing were taken. We have done this for the last five years and feel that it is as valuable an adjunct as non-protein nitrogen or blood sugar in old people.

Incidence by Sex. There were 538 males and 462 females in our series. (Table 3).

TABLE 3
INCIDENCE BY SEX

Male	538
Female	462

Although it is an accepted fact that coronary disease is more prevalent in males than in females, especially in the fourth to the seventh decades, we were surprised to find more males than females requiring, in our opinion, electrocardiograms. This is of interest particularly since in our practice many more females are seen than males and female surgery far outpoints male.

Why Electrocardiograms Were Taken. There was bound to be some overlapping in deciding to evaluate them in this section for many reasons (Table 4). Often a patient was referred for routine check-up and occasionally for a specific cardiac evaluation, as well as for a routine check-up preceding surgery. In our practice patients are referred by doctors merely for an electro-

TABLE 4
WHY ELECTROCARDIOGRAMS WERE TAKEN

Routine	696
Referral	292
Pre-operative	54
Specific cardiac check-up	58
	1100

cardiogram to determine the presence or absence of coronary involvement. Nevertheless, we see that most of the tracings were taken in a routine check-up. By a routine check-up is meant that in the course of examination, whether by the patient's request or in our opinion, electrocardiogram is indicated for proper evaluation.

Mortality Statistics at Survey. In the 1000 consecutive tracings taken (Table 5), 62 patients were dead when the survey was made, but in analyzing the deaths and subtracting those who had died from causes other than cardiac, it was found that the corrected total number of deaths

TABLE 5
ALIVE AND DEAD AT SURVEY

Alive	938
Dead	62
Death rate corrected	41
(21 deaths were due to other causes)	

was 41. The dead were then divided into age, sex, and the number of bundle branch blocks. Our main interest in eliciting the number and types of bundle branch blocks was that we felt it would give us a good index as to the number of bundle branch blocks that one could expect in a thousand cases.

It is seen in Table 6 that the fifth to eighth decades contain the majority of deaths, as one might expect according to national statistics. One died in the third decade from cardiovascular renal disease. There was one death in the fourth decade which is of interest because the patient, a white man aged 40, who had a tracing taken which was interpreted as normal and the

TABLE 6
INCIDENCE OF DEATH ACCORDING TO AGE

30-40 Years	1
40-50 Years	1
50-60 Years	12
60-70 Years	10
70-80 Years	13
80-90 Years	4
	41

opinion confirmed by an outstanding electrocardiographer, died suddenly the following day. It is recognized that this happens but certainly not commonly at this age. This case emphasizes once more the limitations of an electrocardiogram.

Twice as many males were dead as females (Table 7), confirming again that women have more longevity than the stronger sex.

TABLE 7
INCIDENCE OF DEATH BY SEXES

Male	28
Female	13

In the death survey nine bundle branch blocks were seen (Table 8). Here again many of the old S-type blocks were actually right bundle branch blocks as seen in the unipolar leads. We have found that one cannot depend on the limb leads to determine the type of blocks. Approximately an equal number of right and left blocks were present which substantiates other findings that they occur in equal frequency and one cannot say that one type offers a better prognosis than the other.

TABLE 8
INCIDENCE OF BUNDLE BRANCH BLOCK IN 1000 TRACINGS

Right bundle branch block	5
Left bundle branch block	4

SUMMARY

1. One thousand consecutive electrocardiograms were taken from our files (this was over a year and one-half duration) for critical analysis in a practice which is considered to be typical of a general practice. No means were taken to exclude any type of tracing.

2. Unipolar electrocardiography and the concepts of Wilson and Goldberger were used in analyzing these electrocardiograms.

3. It was demonstrated why these tracings were taken.

4. Five hundred seven out of 1000 tracings were normal.

5. The main pathological types encountered were coronary disease, arrhythmias, blocks, hypertrophy and myocardial damage.

6. Out of 1000 tracings, 41 were dead due to cardiac pathology, and these were further divided into age group and sex.

7. Nine bundle branch blocks were found in the dead group, five of which were right and four left.

8. In the dead group by sexes, there were 28 males and 13 females.

9. Analysis by age group shows that the fourth to seventh decades were the ones in which electrocardiograms were most frequently taken.

CONCLUSIONS

1. Unipolar electrocardiography is practical and necessary for the general practitioner to enable him to evaluate properly his cardiac patients.

2. More than 50 per cent of the tracings taken by the average general practitioner may be expected to be within normal limits.

3. The concepts of Wilson and Goldberger enable the general practitioner to locate and delineate cardiac lesions more accurately than with the old system of limb leads and one bipolar precordial lead.

4. The majority of tracings were taken in the fifth to seventh decade and the death rate in the male was double that in the female.

5. From the number of bundle branch blocks found in this series, 0.009 per cent bundle branch blocks can be expected. For practical purposes the death rate was the same in this series.

6. Electrocardiographic positions of the heart must be understood for taking unipolar leads.

7. Limb leads, V-1 to V-6, and augmented unipolar leads were taken routinely and, depending on the rotation of the heart, V-7, V-8, V_3R and VE leads were considered useful and at times necessary.

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X-Ray Findings in Adult Urological Conditions

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This represents a review of the range of urological conditions in whieh radiography can be of serviec and a partial list of the indications for its use. It is intended primarily for those not fully familiar with these procedures.

The prineipal radiographic procedures are the scout film, the pyelogram, the eystogram and the urethrogram. The scout film should include the abdomen and pelvis. This film is an essential preliminary step in radiography. Besides showing calcareous shadows, it shows the size, shape and position of the kidneys and of the psoas muscles. It frequently yields other useful information about the size and position of other abdominal organs, tumors and skeletal abnormalities. The information obtained may warrant scout films in other positions.

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When a retrograde pyelogram is done the patient is first cystoscoped and opaque catheters are introduced into the ureters. Additional films are exposed at this time before or after the contrast medium is injected, or both. The films with the catheters only in place are particularly valuable when the preliminary film has shown a shadow suspected of being a calculus in one of the ureters. Antero-posterior and oblique views will confirm the suspeeted diagnosis by demonstrating the shadow to lie immediately adjaeent to the shadow of the eatheter in both positions and by showing displacement of this shadow proximally along the course of the ureter by the introduction of the catheter. These criteria differentiate a ealculus from a phlebolith and other pelvic and abdominal caleifications. The retrograde pyelogram regularly will provide more reliable information coneerning the anatomy of the upper urinary tracts than any other radiographie procedure.

The excretory pyelogram has proven safe with the use of modern opaque media containing stable radiopaque organic iodine molecules. The technique of the examination and the precautions to be used can be obtained from any modern treatise on urology or radiology. Visualization frequently is less satisfactory than by retrograde pyelography. This method has an advantage, however, in that it provides a fairly good renal function test by observing the concentration and especially the time of appearance in and clearing from the urinary tracts. It is used when retrograde pyelography is contra-indicated or impossible, and also frequently when the symptoms do not seem to warrant cystoscopy.

A high blood urea nitrogen and other evidence of marked renal insufficiency by function tests are considered contra-indications to the use of both methods of urography. They may be contra-indicated also in an acute nephritis.

The cystogram consists of antero-posterior and oblique radiographs made after injection of an opaque solution into the bladder. This solution is then withdrawn and air injected, and one or two additional views are exposed. A special upright film or a view made while the patient strains as if to urinate while the bladder is filled with the opaque material may be used to demonstrate a cystocele in the female.

The urethrogram consists of antero-posterior and oblique or lateral views of the urethra after filling it with an opaque substance.

Developmental anomalies.—These are very common in the urinary tracts. Many of the minor anomalies are compatible with a healthy existence and produce no symptoms. In general, however, it can be stated that malformation predisposes to acquired forms of disease. Since infection is more prone to develop in anomalous urinary tracts than in the normal, a common finding is a recurrent pyuria with the attendant symptom of fever. Some anomalies produce obstruction at some level and the obstruction may cause pain, although not invariably. It does result in urinary stasis which also is a factor in producing infection.

Unilateral absence of the kidney or a supernumerary kidney is quite unusual. Fusion anomalies of various types have been described. The horse shoe kidney is the best known and most common type. In such a case the renal pelves appear rotated. so that the calyces are superimposed, or to the extent that the calyces point medially. Also the pelves are tilted so that their lower poles are nearer the midline than their upper poles. The outline of the kidney, of course, is lost in its lower medial quadrant in the scout film. Rotation anomalies without fusion are fairly frequent.

Duplication anomalies of the urinary tracts are fairly common radiographic findings. They vary from a partial duplication of one renal pelvis to a complete duplication of the pelvis and ureter on one or both sides. Anomalies in position include the ectopic kidney and the hypermobile kidney. The former has never reached its normal level and frequently has a short ureter. It rarely lies on the opposite side of the midline from its normal positions. The hypermobile kidney is normal except that its attachments are unusually long and loose.

Congenital hypoplasia of a kidney, as well as an acquired atrophy of the kidney, are important to recognize since either may be insufficient to sustain life if the other kidney is removed or destroyed. It can be identified by pyelogram and renal function tests.

Congenital polycystic disease of the kidney is nearly always bilateral. The most common symptom is pain. Hematuria or pyuria may occur and a palpable mass is frequently present. The pyelogram is very important. It shows the enlargement of the kidney, elongation, narrowing and distortion of the renal pelves and calyces, especially in the longitudinal direction. The pelvis and calyces remain smooth and are not dilated unless obstruction of the ureter is present. It is very significant that both kidneys show these changes. (Figure 1).

Anomalies of the renal vessels are quite varied and may produce symptoms as well as radiographic findings by compressing the ureter. There are many anomalies of the urinary tract but the above are the most important and common seen by the radiologist in adults.

Calculi.—Urinary calculi vary in their radiographic density according to their chemical composition. Fortunately, the great majority are sufficiently dense to cast a shadow on a plain radiograph. The other means of confirming the location of these shadows with pyelograms and oblique or lateral views have already been mentioned. Pure uric acid calculi are not radio-



Figure 1

paque. These are not common and they may be seen as negative shadows in a pyelogram.

A calculus or multiple calculi may develop and grow to large size in the renal pelvis or a calyx before causing symptoms. A small calculus in the ureter, on the other hand, often causes severe pain of the characteristic type. Repeated scout films may be necessary to trace the progress of a calculus down the ureter. If calculi in the pelvis or calyces reach a size that prevents their dislodgement and continue to grow, they will produce damage to the kidney by direct pressure or obstruction. This may proceed to a condition of calculus pyonephrosis or autonephrectomy.

Infections. Some common infections produce little or no radiographic changes, such as the acute nephritis. The chronic form produces fibrosis and scarring which deforms the pelvis and calyces and may alter the contour of the kidney.

The carbuncle of the kidney and multiple abscesses also may produce no changes in the pyelogram in the early stage. If a calyx is invaded by granulation tissue, it will appear irregular or obliterated on the pyelogram. Calyces may appear narrow due to spasm. A calyx may be distorted by an adjacent parenchymal abscess mass, without communication.

Perinephritis or perinephric abscess will develop when a parenchymal focus of infection penetrates the kidney capsule. The radiographic changes depend upon the extent of infection and the direction of spread. These changes may be shown on plain roentgenograms provided they are of good quality and not obscured by intestinal shadows. The outline of the kidney shadow will be indistinct or lost. Motion of the kidney with respiration and with changes in position is impaired. If the infection spreads down the posoas muscle its lateral outline will be lost and a scoliosis will often develop. A perinephric abscess may become so large as to displace the kidney.

Tuberculosis of the kidney is a large chapter which we are able only to mention briefly. Foci of infection form in the renal pyramids and break down to rupture into the calyces. During this stage of caseation necrosis and ulceration deposits of calcareous salts often form in the renal parenchyma. These, when recognized, are an important radiographic sign. The localized abscess cavity communicating with a calyx is also important. Ulceration and fibrosis extend along the calyces and pelvis producing irregularity and contracture which are visible on the pyelogram. The later extension down the ureter produces a short, straight, but irregular shadow of the ureter on the urogram. Sometimes no symptoms occur until the bladder is involved, resulting in pain or dysuria. At any stage a calyx or the ureter may become so contracted as to cause obstruction. Then dilatation develops proximal to the obstruction and this may cause pain. Pain and pyelographic signs of hydronephrosis or calyectasis may also develop from calculi. (Figure 2).

A chronic non-tuberculous pyelitis or pyelonephritis will often be recognized on the pyelogram only by dilatation of the pelvis and calyces. The necks of the minor calyces frequently become narrowed and their tips "clubbed".

Pyonephrosis is a sequela of pyelitis and is frequently associated with calculi. The renal pelvis contains pus and there is more or less destruction of kidney parenchyma and loss of function. The roentgen signs are calyectasis, hydronephrosis, irregularities in the outline of

the pelvis and calyces, and sometimes irregular contraction. When a calculus occludes a calyx the shadow of the calyx may be obliterated due to non-filling with the contrast medium even though it may be dilated.

Traumatic lessions. Rupture of the kidney results in hemorrhage. A small subcapsular hematoma may develop and be absorbed. Bleeding into the perirenal tissues provides a possible source of suppuration and especially if urine escapes. The radiographic findings depend upon the extent of damage to the kidney and the amount of hemorrhage. The escape of blood or urine obscures the renal outline as does a perinephritis. The kidney outline may be deformed, if visible. Bleeding may be sufficient to displace the kidney. There may be distortion of the pelvis and calyces. (Figure 3).

Renal tumors. These are classified in two groups, as arising in the kidney parenchyma and in the pelvis. Of the benign parenchymal tumors the congenital polycystic disease has already been discussed. The solitary cyst is probably congenital and may enlarge one part of the kidney and produce distortion of the outline of one or more calyces and the renal pelvis depending on size and location. Benign tumors of the pelvis are usually papillomas and show as non-opaque defects in the opaque pyelogram.



Figure 3



Figure 2

It is sometimes possible only to identify a tumor and state its location. Usually one can state whether it arises in the parenchyma or pelvis and whether benign or malignant. The malignant parenchymal tumor will enlarge the kidney shadow, frequently at one pole, and it may displace the kidney and exhibit calcification. The pyelogram shows elongation and narrowing and often displacement of calyces adjacent to the tumor. The terminal cups are distorted, often linear in appearance. The pelvis may be compressed and displaced. When a parenchymal tumor invades a calyx or the pelvis a filling defect is shown, often irregular.

Such a defect is the most important and frequently the only finding in a carcinoma or epithelioma arising within the renal pelvis. In an advanced case distortion of the pelvis and calyces may occur but this is less prominent than in a parenchymal tumor. A filling defect of the pelvis can occur from a blood clot and it is

indistinguishable from a carcinoma of the pelvis, except by repeating the pyclogram later, to show disappearance of the defect.

Tumors of the ureter are not common and appear as small defects within the lumen, frequently producing obstruction and pain. Tumors of the bladder are often recognized as local filling defects in the cystogram, attached to one wall.

The symptom of hematuria is the most important symptom of a tumor of the urinary tract, and it is often the only symptom. Although hematuriah occurs also in non-neoplastic conditions it is a symptom which must never be passed over lightly, but rather should always be investigated thoroughly.

Miscellaneous.—1. Ureteral obstruction. This may occur from a number of causes, such as calculus, neoplasm, infection, trauma and stricture. A stricture may be congenital or acquired. An acquired stricture may arise from causes within the ureter such as calculus, or outside of it, such as infection and trauma. The ureterogram, either retrograde or orthrograde, is a most important source of information as to its location and cause.



Figure 4

2. Prostatism. Of the obstructions at the bladder outlet the most common by far is prostatic hypertrophy. The urethrogram and the cystogram are very valuable aids to cystoscopy in this condition. They help in determining pre-operatively the size of the gland, the relative enlargement of its various lobes, the degree of intravesical protrusion, subvesical enlargement, and elevation of the bladder, in identifying prostatic calculi and other complicating factors, and in differentiating between benign and malignant changes.

The benign prostatic hypertrophy appears in several forms, which lack of space prevents describing in any detail. A common type is illustrated by the case in which the cystogram shows a large, smoothly rounded defect of the floor of the bladder. (Figure 4). The urethrogram shows marked elongation and some total elevation of its prostatic segment. Its contours are smoothly curved, turning anteriorly in its upper portion. Often it is narrowed or flattened transversely and spread somewhat in the antero-posterior direction. The carcinoma of the prostate, on the other hand, produces characteristically a rigidly straight posterior urethra, often with small irregularities but otherwise concentrically narrowed. There is usually not such a marked elongation of the urethra nor as large an intravesical portion.

3. Naturally, the study of the urethra in cases of strictures, extravasations, and the like is not complete without the urethrogram.

CONCLUSIONS

There are several other special radiographic procedures used in this field which we have not included in the above. Obviously we have been able to cover only sketchily and very incompletely the wide range of pathological conditions in which the radiologist is able to assist in diagnosis in the field of adult urology. We have tried to mention the most important and those which are met most frequently in the practice of roentgenography. Unfortunately we are not able to include most of our illustrations in this publication.

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Corrosive Pyloric Stenosis

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Knowledge of the early manifestations and late esophageal complications of an ingested corrosive agent is well known to practitioner and surgeon alike; however, the late gastric sequelae of corrosive poisoning, as evidenced by the paucity of American case reports, would lead one to believe that stomach complications are rare. Perusal of the foreign journals, to the contrary, reveals many interesting case reports pertaining to the subject in question. We wish to report an interesting case of pyloric stenosis without esophageal involvement secondary to lye ingestion, which was managed surgically and re-evaluated clinically and radiologically seventeen months following operation.

Various corrosive agents have been known to cause late gastric stenosis, the most common being those available conmercially, as hydrochloric acid, nitric acid, sulfuric acid, trichloracetic acid and carbolic acid. Other agents reported as causing cicatricial pyloric stenosis are lye, formaldehyde, potassium hydroxide and zinc chloride.

Extrinsic and intrinsic factors play a dominant role in the pathological deformity resulting from an ingested corrosive. The extrinsic factors are the type, quantity and concentration of the ingested chemical, while intrinsically the gastric contents at the time of ingestion and the degree of pylorospasm and antral spasm are significant.

Acids are more prone to involve the stomach. The squamous cell lining of the esophagus is only superficially destroyed by acids, whereas, the delicate, simple columnar epithelium of the stomach is involved in a deeper coagulative-necrotic process. Alkalis, on the other hand, have a tendency to involve both the esophageal and gastric mucosa. Heindl[3], in an analysis of 116 cases of esophageal stricture due to lye ingestion, found an associated pyloric stenosis in only twenty percent of the cases. Statistics show that late involvement of the stomach without esophageal stricture is a rather rare occurrence following lye ingestion. Our case of primary pyloric stenosis, without esophageal involvement, secondary to lye ingestion is therefore significant. Small amounts of dilutely concentrated agents are more likely to result in late gastric sequelae than are higher concentrations. The latter cause early perforation and death due to peritonitis while the former, being better tolerated, remain in the stomach for a prolonged period of time causing more extensive gastric damage.

The most constant site of stricture formation is the pylorus, antrum and lesser curvature. Normally, stratification and storage of ingested foods occurs in the fundus. Fluids entering a full stomach rapidly appear in the duodenum without the admixture of solid gastric contents. The lesser curvature (Magenstrasse) acts as a common pathway for the passage of fluids from the esophagus to the pylorus. Experimental ingestion of a caustic-barium mixture revealed radiologically the rapid passage of the mixture via the Magenstrasse to the pylorus where sudden pyloric and antral spasm halted its further progress.

Boikan and Singer[1] have shown that the status of the stomach, whether full or empty, plays an important role in the extent of the gastric damage. When the corrosive enters the full stomach, it rapidly reaches the pylorus via the magenstrasse, spreading out fanwise in a triangular-shaped area with the base adjacent to the pylorus and the apex towards the cardia. Pylorospasm maintains the corrosive in prolonged direct contact with the pylorus and lesser curvature with the subsequent stricture confined to these areas. With marked and persistent antral spasm, the corrosive destroys a rim of gastric mucosa proximal to the spastic segment, thus explaining the rare occurrence of hour-glass deformity. The retained food partially dilutes the corrosive as well as preventing its contact with the greater curvature.

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Ingestion of a corrosive on an empty stomach, however, results in a more generalized mucosal destruction. Pylorospasm again maintains prolonged contact of the mucosa to the retained corrosive. The absence of dilution and neutralization effect of food results in extensive gastric involvement. The end result may be any of the following: pyloric stenosis, antral stenosis, hour glass deformity or total gastric scarring resembling a linitis plastica. In four of Boikan and Singer's cases, correlation of the status of the stomach and the eventual pathology were in accord with the above concept.

Gross pathological antral and pyloric changes have been variably described in the literature as a tumefaction with a cartilaginous swelling. Moynihan[5] likened the changes to a normal cervix and uterus — "walls are thickened and unyielding, the cavity small." Following the initial corrosive gastritis with slough of the mucus membrane, the gastric wall becomes edematous, indurated and friable with surrounding perigastric adhesions. With progression of the inflammatory process, the edema subsides, the friability decreases and the wall becomes firmer and narrower with the contraction of the residual scar tissue. The depth of the gastric wall necrosis depends on the concentration and duration of contact with the corrosive. Microscopic examination may reveal destruction of the mucosa, sub-mucosa and muscularis layer with their intrinsic plexuses of nerves. The acute inflammatory process characterized by polymorphonuclear infiltration, hyperemia and edema are later replaced by round cell infiltration and fibrosis.

Pathological physiology is related to the destruction of the antral and gastric mucosa with decrease in the gastrin hormone and acid secretion respectively. This apparently explains the low acidity in these cases and the infrequent development of anastomotic ulceration following gastro-enterostomy. Defective gastric motility may result from the destruction of the intrinsic nerves as well as fibrosis of the musculature.

The usual history is that of a patient hospitalized during the acute phase of corrosive poisoning responding to treatment, discharged as cured, only to return at a future date with obstructive manifestations. The onset of the obstructive symptoms following ingestion of a corrosive varies, the most frequent interval being three to six weeks; however, cases have been reported as long as six years later. Anorexia and a sense of fullness after meals are common, usually relieved by vomiting. Cramping epigastric pain, mild to moderate in severity, are frequently present. Intractable vomiting, containing old retained food, is the most persistent symptom and is associated with a notable weight loss. With persistent organic obstruction, inanition, emaciation, dehydration and alkalosis soon follow.

Physical examination reveals evidence of weight loss. Gastrectasis is manifested by a notable epigastric fullness. Visible peristaltic waves may be noted as well as a succussion splash. The radiological findings vary with the extent of the gastric involvement, revealing anything from simple pyloric stenosis, antral contracture, hour-glass deformity, to total gastric involvement. The above gastric pathology may co-exist with an esophageal stricture. Differentiation from carcinoma of the stomach may be impossible without a previous history of corrosive ingestion. Carcinoma may be diagnosed radiologically in spite of an accurate history. Fluoroscopy may reveal motility disturbances, varying from a dilated-atonic stomach to one that is contracted and hyperactive. In the early phase of gastritis, marked antral and pyloric spasm are evident. Changes in the mucosal pattern occur later, and are limited to the areas of involvement.

The treatment of corrosive pyloric stenosis is surgical; the ultimate aim is restoration of gastro-intestinal continuity. The operation of choice will depend on the general condition of the patient and the pathological status of the stomach. Operative procedures used in the past have been digital dilitation of the pylorus, pyloric resection and pyloroplasty, all of which have proven unsatisfactory. Modern choice of therapy varies from jejunostomy, gastro-enterostomy to partial resection of stomach. If the patient manifests early obstructive symptoms during the acute phase of corrosive gastritis, parenteral feedings with adequate decompression followed by laparotomy may be indicated. As emphasized by Meyer and Steigman[4], the stomach at this early stage may be edematous and friable, precluding surgery involving manipulation and suturing of the gastric wall. Preliminary jejunostomy, under these circumstances, is the procedure of choice, since it permits enteral tube

feeding with maintenanee of the patients nutritional status, while the local inflammation subsides. Performance of gastric surgery while the stomach is edematous and friable, entails the danger of poor healing, leaking anastomosis and peritonitis.

If laparotomy reveals, as it usually does when performed in the later stages, a normal appearing stomaeh above the pylorus and antral constriction, the operation of choice is a gastroenterostomy. Partial gastreetomy[2] has reeently been advocated in young patients in view of the possibility of malignant degeneration, stomal uleer formation and difficulty of aecomplishing a satisfatcory gastro-enterestomy in the presenee of diseased gastric tissue. Four cases of partial gastrectomy for benign stenosis have been reported in the literature. We feel that a gastroenterostomy is the simplest and safest proeedure providing the eondition of the gastric wall at the site of anastomosis is normal; however, if at exploration, a morc extensive involvement of the stomach is discovered, whieh would preclude an adequate and safe gastro-enterostomy, and if the eondition of the patient permits, then a partial gastrie resection may be the proeedure of choiee.

Case Report:—Mrs. M. D., a white woman, aged twenty-nine years, was in good health until six weeks prior to admission to the hospital, when while despondent, she took four ounces of concentrated lye solution. This was soon followed by vomiting and epigastric distress. The next day she developed a diarrhea, having a medicinal odor. Epigastric soreness and vomiting of a blood tinged, foul smelling material, persisted for a week. She responded to medical management and was asymptomatic for a period of five weeks when she returned with complaints of persistent vomiting, containing food ingested the previous day. This was accompanied by epigastric cramping pain and a peculiar sensation as if something was moving in the upper abdomen. During the past six weeks, she had lost twenty-six pounds.

Examination was essentially negative except for upper abdominal distention, with evidence of visible peristaltic waves. A fullness in the left upper abdomen with hyper-resonance on percussion was noted. Laboratory findings: Kahn negative; Urine: straw colored, acid, specific gravity 1.027, albumen negative, sugar negative; Blood count: Hemoglobin 78%, RBC 4,010,-000, WBC 6,100, Color index .97; Differential count normal.

Radiological examination was as follows: (Figure 1) The esophagus filled well showing no evidence of



Figure 1. Roentgenogram taken six weeks after ingestion of lye solution with almost complete pyloric obstruction and marked gastric retention.



Figure 2. Roentgenogram taken seventeen months after gastroenterostomy revealing a functioning stoma and complete pyloric obstruction. (Photos by T. Scanlan).

stricture or diverticula. The stomach showed definite retention with a rather marked narrowing and almost complete obstruction at the pyloric antrum. The duodenal bulb could not be adequately filled. Four hour examination showed only a small amount of barium in the terminal ileum, the remainder of the barium is still in the stomach. Conclusion: Marked gastric retention due to almost complete obstruction at the pyloric antrum. No evidence of esophageal stricture.

Patient was admitted to the hospital on June 28, 1948 with a tentative diagnosis of benign pyloric stenosis due to lye ingestion. Pre-operative preparation consisted of continuous gastric suction, parenteral fluids, vitamins and amino acids to restore electrolyte and nutritional balance. Operation was performed on July 6, 1948 under spinal (pontocaine-glucose) anesthesia through a right upper rectus incision. The stomach was dilated but only slightly edematous. The pylorus was firm and thickened, having the consistency of the uterine cervix. The antrum was thickened and indurated and was surrounded by many adhesions. Operation consisted of an anterior, short-loop, isoperistaltic gastro-enterostomy. Patient made an uneventful recovery and was discharged on July 13, 1948. During the past year, she gained thirty pounds. On November 19, 1949, patient was re-examined radiologically with the following report. (Figure 2.) The barium bolus passed readily through the esophagus, revealing it to be of normal caliber. No areas of narrowing, stricture formation or ulceration are present. The gastric mucosal pattern of the upper half of the stomach is intact. The gastro-enterostomy stoma is located anteriorly on the pars media near the greater curvature. Barium passed readily through the gastro-enterostomy stoma. There is no evidence of tenderness, spasm or of an ulcer niche. The upper half of the stomach was never adequatly visualized. Its outline is constantly fixed and shows no distensibility. The duodenal bulb and curve was not visualized. The proximal bowel appears normal. No evidence of stenosis or clumping is seen. Conclusion: Functioning gastro-enterostomy without evidence of tenderness, spasm or niche formation. The pyloric end of the stomach is organically fixed. The esophagus is free of evidence of organic narrowing.

Comment:—Our case is of interest in that it represents a pyloric stenosis secondary to lye ingestion without esophageal involvement. Radiograms taken seventeen months after surgery revealed a progression of the stenosis from partial to complete obstruction. Patients presenting themselves with symptoms of vomiting, weight loss, achlorhydria and roentgenological evidence of pyloric obstruction with a filling defect may easily be mistaken for carcinoma unless an accurate history of previous ingestion is obtained. This is especially significant if the onset of symptoms occurs many months or years following the acute episode. The possibility of late gastric sequelae following the ingestion of a corrosive should be kept in mind, in spite of the fact that the esophagus may be normal.

SUMMARY AND CONCLUSION

1. A case of pyloric obstruction without esophageal involvement occurring six weeks after lye ingestion is reported.
2. Corrosive alkalis, when ingested, commonly cause esophageal stricture alone or in combination with a gastric stricture; rarely do they cause a solitary gastric stenosis.
3. Acids more frequently cause pyloric stenosis without esophageal involvement.
4. The pathogenesis of the lesion varies with the character of the ingested agent (acid or alkali), and the state of the stomach (full or empty).
5. The onset of obstructive symptoms after the acute phase of corrosive poisoning subsides usually occurs within four to six weeks, but may rarely be delayed as long as six years.
6. Differentiation from carcinoma of the stomach may be impossible without an accurate history.
7. Preoperative preparation with decompression and parenteral feeding is essential for good results.
8. Therapy is surgical with a choice between jejunostomy, gastro-enterostomy and partial resection depending on the pathological condition of the stomach and the nutritional status of the patient.

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Established Use of the Antibiotics

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Sometimes it seems to me that a physician trying to keep up with the status of antibiotic therapy today is like a fielder trying to catch a dozen fly balls at once. New antibiotics and new facts on old antibiotics are coming at us so fast that sometimes we have that feeling that all we can do is close our eyes and duck. Before we give up entirely, however, let us see whether we can't reduce the number of balls we have to handle. At the risk, therefore, of appearing arbitrary I shall try to group together certain of the methods of dosage and treatment, hoping thus to simplify the matter sufficiently so that we can all keep the important principles in mind.

First, in considering dosage, I have divided the infections responding to penicilllin into two groups according to how readily they respond to the antibiotic. Among the infections which respond well are pneumococcic pneumonia, streptococcic sore throat and scarlet fever, localized abscesses and gonococcic infections. As shown in Table I, this group of infections may be treated with 300,000 units of aqueous penicillin intramuscularly at 12 or 24-hour intervals, with 300,000 units of procaine penicillin every 24 hours or with 500,000 units of oral penicillin every eight hours. Studies by Dr. Paul Bunn's group and ours[1] have shown that these oral doses result in detectable concentrations of penicillin in the blood approximately half of the time for all persons and for more than half of the time in many individuals. Furthermore, it is much simpler to administer penicillin orally at eight-hour intervals because meals can easiy be spaced so that they do not interfere.

Whenever infections are caused by organisms which are more resistant to penicillin or where penetration of penicillin into the site of the infection is impaired, the disease has been placed in the less responsive category. This includes infections with resistant staphylococci as well as meningitis and endocarditis. For these infections penicillin is recommended in doses of 2 cc. to 8 cc. every six to 12 hours, or in frequent intramuscular injections, or by continuous intravenous injection in doses up to 40 million units a day. Higher serum concentrations of penicillin may be obtained if carinamide or benemid is employed in addition.

Aureomycin and terramycin can be given in oral doses of 1 gm. initially and 0.5 gm. every six hours. Children may be given 25 mg. per Kg. initially, followed by 50 mg. per Kg. per day divided into three to six equal doses. Chloramphenicol is given in double these amounts.

Intravenous aureomycin is recommended in doses of 7 mg. per Kg. every 12 hours.

In Table 2 are listed the drugs of first and second choice for various infections. Penicillin is preferred for infections caused by hemolytic streptococci, although aureomycin and terramycin have been found to be satisfactory. In pneumococcic pneumonia or empyema, aureomycin, penicillin, or terramycin may be employed. It is possible that aureomycin or terramycin may be superior to penicillin because they control infections with gram-negative rods also. Chloramphenicol has also been found to be satisfactory in these infections but has not as yet received extensive trial. In pneumococcic meningitis or endocarditis, reliance should be placed on penicillin because the dose can be increased almost *ad infinitum* if necessary. Staphylococcic infections are quite responsive to aureomycin and, except in the rare case of very highy resistant organisms, to penicillin also. Chloramphenicol and terramycin have not as yet received extensive trial.

Penicillin is the main stand-by in endocarditis caused by alpha and gamma streptococci, although aureomycin and streptomycin have been found to be preferable in certain individual instances. Where the organism is highly resistant to the individual antibiotics, combination therapy should be tried.

In gonococcic infections, aureomycin, chloramphenicol, penicillin and terramycin are all effective. For meningococcic menigitis nothing

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TABLE 1
Recommended Doses of Antibiotics

Antibiotic	Route	Preparation and Dose	Interval
Penicillin	i.m.	aqueous crystalline 300,000 units	12 or 24 hrs.
(very responsive infections)	i.m.	procaine aqueous or in oil 300,000 units	24 hrs.
	oral	tablets 500,000 units	8 hrs.
(less responsive infections)	i.m.	procaine aqueous 600,000 to 2,400,000 units (2 to 8 cc.)	6 to 12 hrs.
	i.m.	aqueous crystalline 1 to 2 million units	2 hrs.
	i.v.	aqueous crystalline ½ to 40 million units per day	continuous infusion
Aureomycin	oral	1 gm.	initially
	(adults)	0.5 gm.	6 hrs.
	oral	25 mg./Kg.	initially
	(children)	50 mg./Kg./day	6 hrs.
	i.v.	7 mg./Kg.	12 hrs.
Terramycin	oral	1 gm.	initially
	(adults)	0.5 gm.	6 hrs.
	oral	25 mg./Kg.	initially
	(children)	50 mg./Kg./day	6 hrs.
Chloramphenicol	oral	2 to 4 gm.	initially
	(adults)	1 gm.	6 or 8 hrs.
	oral	50 mg./Kg.	initially
	(children)	100 mg./Kg./day	6 hrs.
	rectal	25% greater than oral	

has been found to be superior to sulfadiazine. Gantrisin may be used instead because of its greater solubility. Penicillin should be used in addition if the Waterhouse-Friderichsen syndrome is suspected.

Chloramphenicol is the drug of choice in typhoid and paratyphoid fevers and probably in other salmonella infections. Aureomycin is effective but to a lesser degree.

Sulfadiazine has been shown by comprehensive studies to be superior to the other sulfonamides in bacillary dysentery. Until similar studies have been carried out with the newer antibiotics, I believe sulfadiazine should be the drug of first choice.

Since so many urinary infections are mild and easily controlled, it seems wisest for the physician to use sulfonamides initially in these conditions and to reserve the newer antibiotics for those cases where there is no response. Where the infection is still recalcitrant, combinations of antibiotics may be effective.

When proteus or pseudomonas (pyocyaneus) is the causative agent, aureomycin and terramycin are rarely efficacious. In some of these cases, streptomycin or occasionally chloramphenicol may clear up the infection.

Klebsiella (Friedlander) infections respond well to aureomycin or chloramphenicol. Streptomycin is not recommended as the drug of first choice because the duration of treatment is often so long that eighth nerve damage may develop.

The course of pertussis is apparently shortened by the use of aureomycin, chloramphenicol, or terramycin. In Hemophilus influenzae infections, on the other hand, I do not believe that these drugs have been demonstrated as yet to be superior to streptomycin. At present, therefore, I would advocate streptomycin in all cases, combined with one of the newer antibiotics or with sulfadiazine.

Brucellosis responds to all three of the newer antibiotics, but animal studies and preliminary investigations in patients, indicate that a combination of aureomycin and streptomycin gives the best results.

In tularemia, aureomycin, chloramphenicol, and streptomycin are all effective. Streptomycin is listed as less desirable because of its tendency to involve the eighth nerve.

TABLE 2
Antimicrobial Agents Recommended in Various Infections

Infection	First Choice	Second Choice
Coccal Diseases		
Beta hemolytic streptococcic infections	P	A or T
Pneumococcic pneumonia and empyema	A, P, or T	C
Pneumococcic meningitis and endocarditis	P	——
Staphylococcic infections	A or P	——
Alpha and Gamma streptococcic endocarditis	P	A, C, T, or St*
Gonococcic infections	A, C, P, or T	St
Meningococcic meningitis	Su	——
Bacillary Diseases		
Typhoid and salmonella infections	C	A
Shigellosis	Su	A, C, or T
Coli, aerogenes and related urinary infections	Su	A, C, or T
Proteus infections	St	C
Pseudomonas infections	St	C
Klebsiella infections	A or C	St plus Su
Pertussis	A, C, or T	——
H. influenzae	St plus A, C, T, or Su	——
Brucellosis	A plus St	A, C, or T
Tularemia	A or C	St
Gas gangrene	P plus specific serum	——
Tuberculosis	St plus paraminosalicylic acid or promizole	——
Rickettsial and Viral Diseases		
Rickettsial infections	A, C, or T	——
Lymphogranuloma venereum	A	——
Primary atypical pneumonia	A, C, or T	——
Herpes zoster	A, C, or T	——
Psittacosis	A	P
Other Infections		
Syphilis	P	A or C
Amebiasis	A, C, or T	——

*Combination therapy may be desirable.

Designation of Symbols

A — Aureomycin
C — Chloramphenicol
P — Penicillin
St — Streptomycin
Su — Sulfonamides
T — Terramycin

The results of the treatment of gas gangrene are none too satisfactory. At present a combination of specific serum and penicillin is the best method available. In tuberculosis the addition of para-aminosalicylic acid, promizole or a related sulfone, to streptomycin gives better results than streptomycin alone.

All of the rickettsial infections apparently respond equally well to aureomycin, chloramphenicol and terramycin. The same is true of primary atypical pneumonia and herpes zoster. In psittacosis, aureomycin and penicillin are effective.

Until long-term studies can be carried out with the newer antibiotics, penicillin remains the drug of choice in syphilis, although aureomycin and chloramphenicol have been demonstrated

to be effective. All three of the newer antibiotics are recommended in amebiasis.

Combinations of Antimicrobial Agents.—On *a priori* grounds it would seem likely that if bacteria were susceptible to each of two different antimicrobial agents, the combination of the two would be more effective than either agent alone. That the matter is not so simple as this, will appear when we examine the evidence. Let us consider first some of the reasons why combinations of therapeutic agents might be desirable:

(1) In the case of infections containing a mixture of bacteria, one therapeutic agent might be effective against one group of bacteria and another agent might be effective against another group.

(2) Penetration into the area of infection might be different for the different antimicrobial agents.

(3) By giving similar amounts of two therapeutic agents the side effects which would result from the use of large amounts of one of the agents alone might be prevented.

(4) Employment of a second antimicrobial agent might prevent or delay the appearance of bacteria which would be resistant to the first agent if it were used alone.

(5) A synergistic or additive action might result from the use of two antimicrobial agents if one agent would kill only a portion of the bacteria, if used alone, and the second agent would account for the remainder of the bacteria.

The presence of mixed infections is advanced as the reason for the use of penicillin and streptomycin, or penicillin and sulfonamides, in the peritonitis which results from the rupture of a viscus. The action of streptomycin (or sulfonamides) on the gram-negative rods complements the action of penicillin on the gram-positive cocci. The work of Yeager and is associates,[2] however, makes it likely that aureomycin, which includes both groups of organisms in its antibacterial spectrum, gives results as good or better than combinations of penicillin and streptomycin.

Staphylococcic infections may develop in patients during treatment with streptomycin for other infections. Administration of sulfonamides or antibiotics effective against gram-positive cocci, along with the streptomycin, may prevent this complication from developing.

An example of the second reason, penetration into a focus of infection, is the advocacy of combinations of sulfonamides and penicillin in the treatment of pneumococcic meningitis on the theory that penicillin would not cross the blood-brain barrier in sufficient amounts. Many observers have shown, however, that if penicillin is given in large enough doses penetration into the cerebrospinal fluid does occur. Furthermore, my associates and I have found[3] that when large intramuscular doses of penicillin are given to patients with pneumococcic meningitis it is not necessary to give sulfonamides in addition.

In considering reason Number 3, we should bear in mind that while the dose of penicillin can be raised enormously without any ill effects, this is not true of streptomycin, since the toxic action of this drug on the eighth nerve is more pronounced when large doses are employed. Consequently, in tuberculosis it is advisable to combine streptomycin and promizole or para-aminosalicylic acid. Another reason for the concomitant use of two drugs in tuberculosis is the fact that strains of tubercle bacilli which are resistant to streptomycin do not make their appearance so soon when another inhibiting drug, such as para-aminosalicylic acid, is used in addition. The employment of this combination in tuberculosis is, therefore, also an example of the fourth reason, namely, the fact that the employment of combinations of agents may retard the development of resistance to those agents. Pulaski and Baker[4] have shown that combinations of streptomycin, penicillin, and sulfonamides retard the development of resistance in the case of the gram-negative rods. Klein and Kimmelman[5] had the same results when they worked with Staphylococcus aureus and other organisms.

Perhaps the most challenging problem today is whether there is a synergistic effect which makes it possible to treat infections with combinations of antimicrobial agents when they will not respond to either drug alone. It has been shown that streptomycin and sulfonamides are effective in brucellosis when one of these drugs alone has little or no effect. Aureomycin or chloramphenicol alone appear to be more effective than the combination of streptomycin and sulfonamides, but recent studies make it likely that a combination of aureomycin and streptomycin is still better.[6 7 8] In the case of enterococci, Jawetz, Gunnison and Coleman[9] have demonstrated *in vitro* that penicillin and strep-

tomycin were much more effective than either drug alone. Eagle and Fleischman[10] demonstrated a definite synergistic effect of penicillin and bacitracin in rabbit syphilis. In a case of staphyloccic endocarditis my associates and I[11] were able to show *in vitro* that a combination of aureomycin and penicillin exerted a synergistic effect upon the staphylococcus. When these two antibiotics were administered simultaneously, the patient recovered from the infection, although each of these therapeutic agents, when given alone, had been effective.

This brings up a most important point, namely, that the value of combinations of drugs must be tested *in vivo,* in animals, and eventually in patients. *In vitro* studies are not enough. Several investigators [12] [13] [14] have shown, for instance, that the addition of sulfonamides to penicillin retards the action of the penicillin for several hours. Jawetz and Speck[15] found this to be true when chloramphenicol was added to penicillin *in vitro.*

These findings accentuate the need for clinical trial in the patient and are the basis of the following recommendations for practical use of combinations of antimicrobial agents in clinical practice today.

(1) These combinations should not be used in a shotgun fashion, on the theory that if one antibotic will accomplish something, two or three will accomplish more. Frequently a single antibiotic may be found with a broad enough spectrum to take care of a mixed infection. Aureomycin in peritonitis due to a ruptured viscus is an example of this. Likewise, there is some evidence that aureomycin and terramycin may be superior to penicillin in the treatment of the pneumonias because the former antibiotics are effective against gram-negative rods and the causative agents of primary atypical pneumonia as well as against gram-positive cocci. In other instances, the dose of a single antibiotic may be increased rather than adding another therapeutic agent. The successful employment of large doses of penicillin in bacteria endocarditis caused by relatively resistant organisms is an example of this.

(2) Where combinations of antimicrobial agents have been demonstrated to be of value in a certain disease, these combinations may be used routinely in all cases of that disease. At present the combined use of streptomycin and aureomycin in brucellosis appears to be the optimal method of therapy for that disease.

(3) Where antibiotics have been found unsuccessful in the treatment of a given patient's infections, or where the *in vitro* resistance of the organism makes it unlikely that any individual antibiotic will be successful, *in vitro* tests for effective combinations of antibiotics should be tried. If a synergistic effect is produced by any combination of agents, that combination may then be used. Endocarditis and recalcitrant urinary tract infections are examples of conditions in which this method is likey to produce results.

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The Lost Art of Diagnosing With the Eyes and Ears

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Dr. Alvarez: Today I feel great need for pointing out that, although of late medicine has been advancing and developing wonderfully well along certain lines, along one line it has been going badly. There is too great a tendency, especially among young physicians, to rely mainly on the laboratory and the x-ray departments for the making of their diagnoses.

Thus, at the Mayo Clinic, where I studied this problem for 25 years, I found that while most of the brilliant young doctors who came from our great universities knew more than I did about diagnosing rare diseases with the help of laboratory reports, often my older colleagues and I, with the help of only our eyes and ears, were able to make a diagnosis that was more pertinent than the one made in the laboratory. Thus, while a young colleague was keenly studying a high blood cholesterol or a somewhat abnormal sugar tolerance curve, or some diverticula of the colon, he might be failing to look at the man keenly enough to see that he was ill only because he had had a little stroke or an attack of encephalitis.

Most of the patients who are seen at a place like the Mayo Clinic have already been studied thoroughly elsewhere, and by able internists. Often, of course, the diagnosis the patient brings is correct, but when it is wrong or, more often, inadequate to explain all the symptoms, one usually finds that the mistake made was due to the failure of the physicians to look shrewdly at the patient or to talk with him. In many a case, even one question would have shown that the diagnosis was inadequate, or it would have led to the making of a more pertinent one.

To illustrate what I mean: not infrequently I see a patient, sent with the diagnosis of a duodenal ulcer made by a roentgenologist. A Sippy treatment for ulcer did not help. If only the local physician had asked one question he would have seen that his diagnosis was wrong. If he had only asked the man, "When did you have hunger pain in the pit of your stomach, relieved by eating?" the fellow would have said "Oh, that was 20 years ago. I haven't had any of that trouble since!" Then the doctor would have known that what the roentgenologist saw was only a scar, and that the cause of the symptoms being complained of had yet to be found.

To show the extremes to which the modern lack of observation of patients can now go: the other day I saw an elderly man who complained of abdominal pain. Gastro-enterologists had tried to relieve this, and had had his digestive tract roentgenographed several times, hoping to find an ulcer. When the man came in and I shook his hand I was immediately impressed by the fact that it was clumsy and clammy. It did not feel right. Looking down at it, I saw a shiny red hand, the skin of which, evidently, had suffered marked trophic changes. A few questions brought out the facts that the abdominal pain had come suddenly, with a bad dizzy spell. With this there had come the changes in the hand and an inability to concentrate on work. Obviously, the man had had a little stroke which had injured the center for the hand and in some curious way had sent a storm down the vagus nerves to the stomach.

A while ago I saw another man like this who had been examined by several internists, all of whom had been concerned only with a slight increase in blood pressure, a left bundle branch block, which was not producing symptoms, and some minor disturbances in renal function. When I saw the fellow I was impressed by the fact that something must have hit his brain and hit it hard. He did not look like the sort of fellow who could be a prominent attorney, and that is what he said he had been. His answers to questions were slow, and his face was expression-

less and uninterested. His eyes did not light up. He had a slight weakness and tremor of the muscles on the right side of his face. He had a little drooling of saliva at one corner of his mouth, and he had a little egg on his chin.

As I could not get much of a history out of him, I took his wife into the next room and asked her if her husband had changed. She said, "Yes, he is a very different man since he had that spell in October in which he fell down." I was much impressed by the fact that he could not work any more; he couldn't even read as he used to do. Obviously he had had a stroke.

One difficulty in university medical schools today is that most of the teachers are so highly interested in rare diseases that they are constantly showing cases of these diseases to the students. As a result, a student comes to know much about such rare diseases as Ayerza's syndrome, pheochromocytomas or potassium deficiency, but he doesn't know the commonly seen, frail little constitutionally inadequate type of woman the minute he sees her. He is not able to recognize common hysteria at a glance. He cannot recognize on sight a mildly psychotic patient, and often he doesn't even notice that a patient is walking in a curious way. He is not able to recognize the different gaits or postures which can be so helpful diagnostically.

I often say that so long as a psychotic patient does not punch his doctor in the jaw, he can go through the man's office or through a great diagnostic clinic and come out on the other side with the report that he is perfectly well. Many a time I have seen this happen. I remember the melancholiac, much depressed wife of a professor who came from a university hospital with a diagnosis of amebiasis! The medical head of a big life insurance company once asked me to see one of his branch office heads, who, formerly, had been a very able and successful man. But for a year his office had been going down hill. His chief had sent the man to several internists but he had always come back with a clean bill of health. When I saw him I immediately recognized hypomania. The man was too talkative and pally and excitable. I went out to the waiting-room, found his wife and had a chat with her. She said "Yes, he is now in one of his excitable stages, but soon he will be down in the depths, crying and wringing his hands and talking of suicide." Evidently, here was a manic depressive man who should have been in an asylum, getting shock treatments, but when in a doctor's office he behaved so well that his hypomania was not noticed.

Today one of the greatest difficulties with medicine is that often the consultant does not take the patient's history. He lets his nurse or an assistant do that. Then the patient is sent for a lot of tests and x-ray studies, and finally the Chief sees him or her for ten minutes. During this time the doctor just looks through the laboratory reports and accepts any diagnosis that appears to have been made for him. As I pointed out, he hardly looks at the man, and, of course, has no time in which to get acquainted with him. It probably never occurs to him, also, to talk to the family to see what the patient's psychic situation is.

A few times in my life, when, in a hurried day, I have tried to practice this type of what I call decerebrate medicine, I promptly got myself into serious trouble or nearly made a bad mistake. For instance, one day while hurrying so that I could leave on a train, I found a stout, nice-looking woman of 45 who, from the record, had given a typical story of a common duct stone. I was all set to refer her to a surgeon when I said to myself, "No, here I am, practicing the type of medicine which I am always decrying." Accordingly, I started taking my own history. It had already been taken on several occasions by three young physicians who all agreed that after years of suffering "gallstone colics", the woman had been operated on and a gallbladder full of stones had been removed. Following this, she had gone on having the "colics." It was stated also, that once she had been jaundiced; sometimes she had had chills; and sometimes fever. Obviously, this was the typical story of a common duct stone.

But when I said to her, "How bad is your pain during a colic? Do you need morphine?" I was startled to hear her say, "Why, I have no pain; I never had a pain in my life." I asked then what she did have, and she said she had spells in which she vomited for a day or two. I asked, "Does the vomiting spell begin with a headache?" "Yes," she said, "over my right eye." In a minute I had the typical story of migraine, and of gallstones which had never given her any pain or distress. That is why their removal had had no effect on the syndrome.

Her migrainous attacks came because she was married to a man twenty years older whom she did not much like. Why did the young doctors write "colic?" Doubtless because, knowing from x-ray work that she had gall stones, they assumed that her spells must be colics.

I asked her then, "How about the jaundice?" She said, "Oh, your assistant was so determined that at some time I must have had jaundice that I finally said that I had it in order to get rid of him!" The "chills" turned out to be a nervous chill which she had once after an argument with her husband; and the fever turned out to be an insignificant 99.6 on some days when she was nervous. How grateful I then was that I had not sent her in for a useless operation.

I am often greatly interested to see what nowadays able physicians do not notice. Thus, I was asked to see an elderly man whose feeling of great fatigue had appeared to be inexplicable, even after many examinations. On coming into the room I noticed that he was wearing big rubber winter galoshes. I asked him what he was doing with those on, on a hot day in July. "Oh, I'm so cold," he answered. The diagnosis then was obvious, and a test showed a basal metabolic rate of minus 38 percent.

Another patient was referred to me by a distinguished professor of medicine for an "amoebic dysentery" which had not been relieved by much treatment with emetin and carbarsone. On shaking hands with the man, my assistant noticed a hand which felt feverish; and on looking into the man's eyes, he saw a rather frightened look of a person with exophthalmic goiter. Actually, the man had a basal metabolic rate of plus 65, and removal of most of his thyroid gland brought instant relief. In this case, if the professor had only asked the man one question he would have realized that he was not dealing with dysentery. I said to the man, "What do your bowl movements look like? Are they bloody, or mucous, or watery or mushy?" He said, "They consist of little, round, hard balls!" This so-called diarrhea stopped the day the thyroid gland was removed.

It is unfortunate that today a tremendous amount of the laboratory and x-ray work which is done is wasted. For instance, as I was writing the notes for this talk, I was called to see a man who, because of abdominal discomfort, had had several x-ray studies made of the digestive tract. A glance at him showed that he was depressed and schizoid. On talking to his family, I found that for some time he had been in a depression. He was a man forty years of age who had never married or showed any interest in girls. More questioning of the family showed that his aunt is in an insane asylum.

I said to the brother who was giving me the information, "Why didn't you tell your doctor all this before you left Virginia to come to Chicago?" He said, "I tried to tell him but he was so busy that eventually he got angry with me and told me not to bother him." Each time the brother got worse the doctor sent him for more x-ray studies.

In the clinic in which I used to work, the older members of the Staff each year used to cancel bills for around a quarter of a million dollars worth of laboratory and x-ray work which they felt had not been necessary and should not have been ordered by the assistants. For instance, one evening I saw a young woman who had been given orders for over two hundred dollars worth of laboratory work, when her only complaint was insomnia! Just one question showed that her trouble was all due to the fact that her fiance had started going out with another girl. In another case an old man with a fixed tumor in his epigastrium and the story of a loss of 30 lbs. in weight had been given almost every conceivable test by the brilliant young graduate of a great university medical school. The patient brought with him an x-ray film showing an inoperable carcinoma of the stomach! When I asked the assistant why he had spent ten days studying the man with many tests his answer was that he had been trained to do that to every patient.

All of this can be summed up in one sentence. What we need in medicine today is more observation and more taking of histories and less ordering of useless tests. They are useless when the diagnosis can be made without them.

Dr. Robert W. Keeton, Professor of Medicine: One problem which we frequently meet is the reluctance of the psychoneurotic patient to accept the diagnosis. Sometimes some laboratory tests can be of great help in convincing the patient of the correctness of the diagnosis.

Dr. Alvarez: That is very true. Often the hardest job I have is to sell the diagnosis of a neurosis to the patient. She doesn't want that diagnosis.

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

An Intramedullary Epidermoid Tumor

Milton Tinsley, M.D.* and Archibald D. McCoy, M.D.**
Chicago

The diagnosis of primary tumors involving the spinal cord can sometimes be very confusing, especially in those patients who have many complaints and just enough objective findings to substantiate at least a significant portion of their subjective difficulties. Frequently the differentiation between metastatic and primary tumors of the spinal cord is an added diagnostic difficulty. The arrival at a correct diagnosis therefore requires a continuation of repeated neurological examinations, amplification of the history, and exhaustion of all laboratory methods. Even at the arrival of a presumptive diagnosis which may explain most of the objective phenomena we are always harrassed by a few unexplainable findings. Just such a problem confronted us recently when a patient who had been under treatment for a gynecological disorder presented neurological findings, portions of which were eventually explained by verified pathological specimen as an intramedullary epidermoid cyst of the dorsal cord. There were, however, other findings which strongly suggested a degenerative disease of the central nervous system such as multiple sclerosis.

J.J., a 37 year old white single female was seen by the Neurosurgical Service of the Cook County Hospital on Sept. 15, 1949 at the request of the Gynecological Service who had been treating her for a tubo-ovarian abscess. Her complaints were those of headaches, fatigue, difficulty in maintaining equilibrium, numbness of the right foot, and weakness of the left leg. There was a history of "shooting pains" two years previously which started in the right groin and radiated to the right knee and foot. The pain was not aggrevated by movement and subsided without treatment.

Neurological examination revealed the following; (1) horizontal nysatgmus on lateral and upward gaze, (2) hyperactive deep tendon reflexes especially in the left knee and ankle, (3) left Chaddock and Babinski responses, (4) spastic weakness of all muscle groups of the left lower extremity, (5) diminished position sense on the right, (6) absent vibratory sense bilaterally up to the level of the xiphoid, (7) bilaterally diminished sensation to pin-prick with a level just above the nipple line, (8) bilateral impairment of light touch in the lower extremities, (9) markedly positive Romberg sign with falling

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to the left, (10) bilateral ataxia of finger-to-finger and finger-to-nose movements. A lumbar puncture showed clear, colorless spinal fluid under normal pressure with a negative Pandy reaction, no cells, and a total protein of 8 mgms. percent and a glucose content of 20 mgms. percent. Pantopaque myelography was then carried out which illustrated a crescentic defect in the column in the region of T_4 and T_6.

It was felt at that time that her difficulties might represent a syringomyelia or a spinal cord tumor. However, in considering a spinal cord tumor it was deemed essential to rule out a primary pelvic neoplasm with metastasis, and for this reason cervical biopsies were made which revealed nothing unusual. Since the patient had an adnexal mass a total hysterectomy and a left salpingectomy was done as treatment for a chronic salpingitis and endometritis with pelvic adhesions. This ruled out the likelihood of the cord tumor being a metastasis from the pelvis.

With the neurological picture confirmed by the myelographic findings it was elected to do a thoracic laminectomy. On opening the dura the cord was swollen and yellowish in appearance, filling the entire intradural space. The cord was needled but no fluid was obtained. A longitudinal incision was made at the posterior raphe and a large tumor mass encountered which contained yellow granular material. This was evacuated with a spoon, leaving a glistening membrane. The membrane was then picked up and dissected from the spinal cord in its entirety. This left the cord completely decompressed. The pathologist reported the specimen to consist of numerous fragments of tissue, greenish-gray to brown-gray and somewhat calcareous in appearance. The largest fragment measured 15 x 15 x 5 mms. On sectioning the tissue it appeared to be laminated and of a brown-gray coloration. Microscopic examination revealed a degenerated epithelial cyst composed of degenerated epithelial cells, calcium, and cholesterol. (Figure 1)

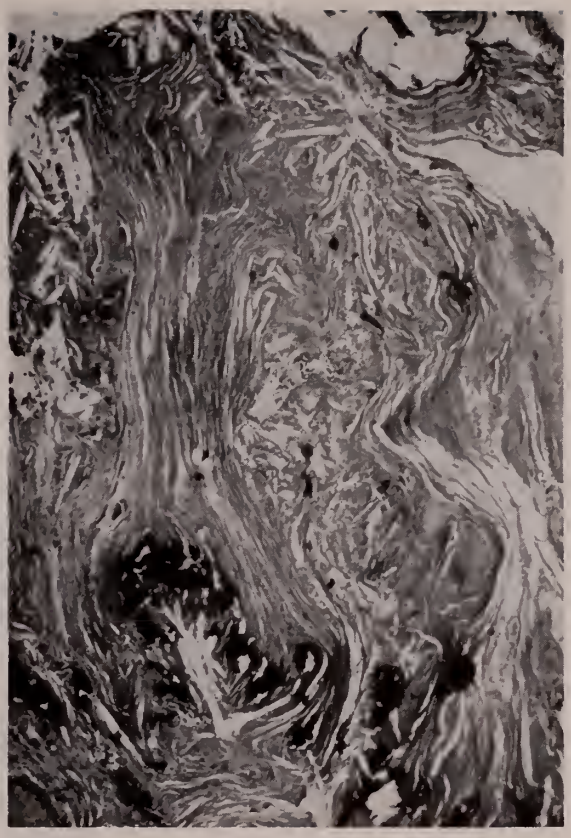


Figure 1. This illustrates the structure of the walls of the degenerated epithelial cyst which are composed of degenerated epithelial cells along with calcareous and cholesterol deposits.

Following surgery our patient developed a wound infection which responded promptly to penicillin therapy. At the time of discharge she had return of position sense, and her pyramidal tract signs had subsided along with the bowel and bladder difficulty. She was re-admitted on May 1, 1950 because of persistent pain, especially at the operative site, which radiated down her arms and lasted from two to three hours at a time. A lumbar puncture was done and the cerebrospinal fluid was seen to contain the normal chemical constituents and to be under normal pressure and exhibit normal dynamics. A course of x-ray therapy over the incision was given without significant relief of pain. A procaine intercostal block was done during one of her episodes of pain which gave her complete temporary relief. She was subsequently subjected to a posterior rhizotomy of D4,5 and 6 roots, bilaterally. At this time the spinal cord was observed to have a normal appearance with the exception of some arachnoidal adhesions which were divided. From this time on she was free of her radicular pain and was able to return to her work as a waitress.

This patient's findings suggested the possibility of three pathological conditions. These were multiple metastatic cord lesions, because of the nystagmus, muscular weakness and contralateral

root pain along with a pelvic mass which had not been pathologically diagnosed; secondly, multiple sclerosis because of the nystagmus, difficulty in maintaining equilibrium, fatigue, weakness of one leg, and headaches; thirdly a primary cord tumor, which she really had, as evidenced by myelographic findings at T_4-T_6 level and varified at the operating table. The laminectomy was performed only after a primary malignancy of the pelvis had been ruled out by gynecological procedures.

In 1939 Boldrey and Elvidge[1] analyzed the literature on dermoid cysts of the vertebral canal, and in 1943 Craig[2] further classified the literature and added his own case of a subpial epidermoid tumor of the spinal canal in the lumbosacral region. In 1949 Sachs and Horrax[3] presented a classical analysis of the subject and found 27 reported cases of intraspinal epidermoids, with only six reported as intramedullary tumors.

SUMMARY

This case illustrates that in spite of the presence of nystagmus, normal cerebrospinal fluid protein and dynamics, we were led to believe that an intraspinal tumor was present and this was verified by myelography. We decided against a diagnosis of multiple sclerosis because of the character and severity of the patient's pain, which spoke more for a spinal cord tumor. Recovery followed removal of the intramedullary epidermoid tumor.

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THE RESEARCH PHYSICIAN

We are all familiar with the attitude of many practicing physicians toward their colleagues who spend their lives in research. They themselves are intensely busy men, dealing constantly with practical matters, carrying a heavy load of responsibility and exposed to all the buffets and anxieties that a man must face when he practices his profession in a competitive world. We cannot, therefore, be surprised if the practitioner, although paying lip service to the intellectual attainments of his colleague in research, regards him in his heart as rather a poor fish. There the research man sits, he thinks, with a secure salary, protected in his ivory tower from the rough-and-tumble of the world and with nothing to do but the work of his own choice; has not such a man chosen the easy way?

Indeed he has not, as anyone who has had personal experience in research very well knows. It is true that he is sheltered from the world, but his task is an exacting one. Much of his effort ends in frustration and disappointment, and he is largely denied the immediate satisfaction that comes from the visible result of a practical task well done. It is indeed not uncommon to find men for whom the psychologic strain of full-time research becomes too great and who seek refuge in work of which the immediate results are more apparent. *Excerpt: The Shattuck Lecture: The Role of the Basic Sciences in Medical Research, Sir Charles Harington, M.A., Sc.D., F.R.S., N.E.J.M., May 24, 1951.*

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR

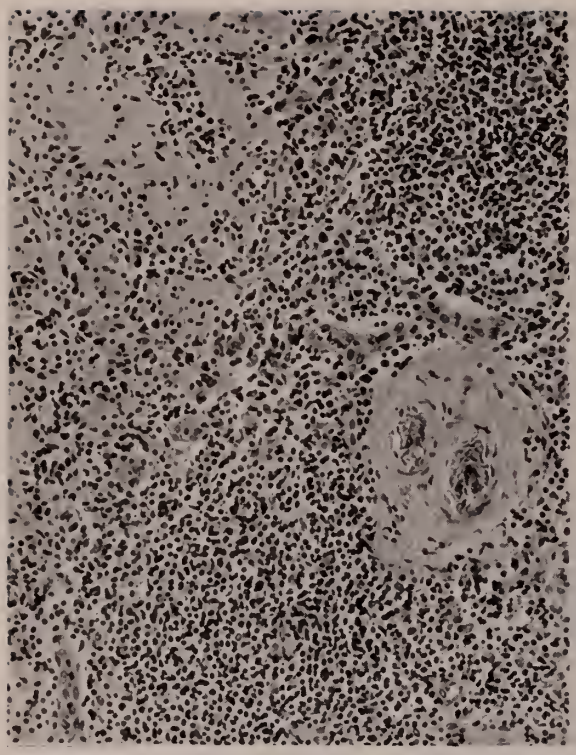


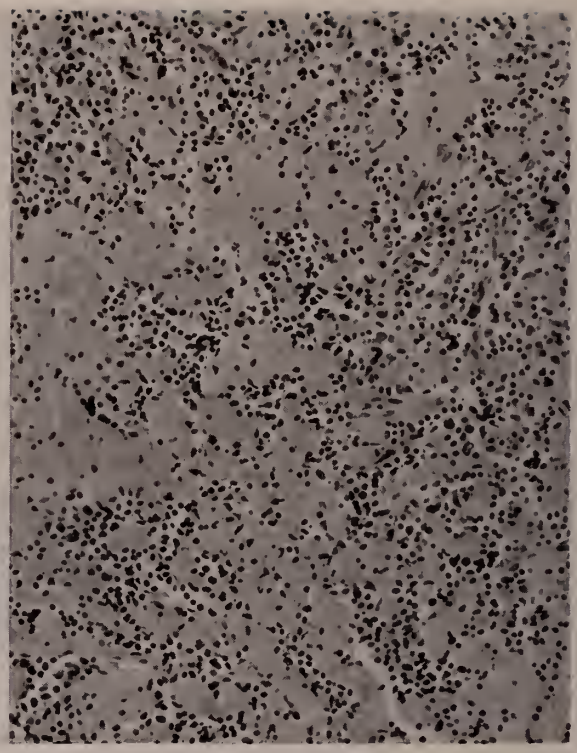
Presentation of Three Cases

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RETICULUM LYMPHOSARCOMA INVASION OF THE LUNG

A white woman aged 50 years entered St. Luke's Hospital for the sixth time on July 31, 1950 in the eare of Doctor R. M. Galt. Her right middle and ring fingers became swollen, stiff and painful in 1943 and again in 1946. Simple remedies relieved this. The right knee, the right shoulder and neek in 1947 became painful but were not stiff or swollen. External heat and aetive motion gave relief. Later in 1947 a eholeeysteetomy was done. In 1948 the patient noted diffieulty in breathing and had a productive cough. Roentgen films had mottled regions of density in the lower lobe of eaeh lung. These changes were thought to be pneumonia. A severe eold in November of 1949 was attended by hoarseness and shortness of breath. The hoarseness remained and the dyspnoea grew worse. Her complaints were summarized in March 1950 as shortness of breath for 9 months, hoarseness for 5 months and paroxysms of eoughing for 2 months. Then enlarged cervical and axillary lymph nodes were found. A eervieal node removed for examination had many large and small hyaline scars (Figures 1 and 2) and moderate numbers of large mononuclear reticulum cells. These hyaline masses were the conspicuous ehanges. In erevices and along the margins of the hyaline material were a few large mononuelear cells, considered to be atypieal retieulum eells and different in strueture from other mononuelear phagocytes. Some of these atypieal eells were in mitosis. The changes in the lymph nodes were interpreted as an unusual variant of reticulum lymphosarcoma. An axillary lymph node removed for diagnostic eonfirmation, had similar ehanges. During the patient's admission in March 1950 her temperature ranged to 100.2°F., the pulse was 120 and the respirations 38 per minute. The lungs were flat by percussion, had loud rhonchi, rales and bronehial breathing. The cervical and axillary lymph nodes were large. The leukoeytes of the blood ranged between 1,200 and 2,400 per cu. mm., the erythroeytes were 4,840,000 per cu. mm. and the hemoglobin was 12 grams per cent. The sputum had no acid-fast bacilli, the sedi-





Figures 1 and 2. Photomicrographs illustrating the hyaline masses observed in the enlarged cervical and axillary lymph nodes removed surgically. X-198

mentation rate of the blood was 17 mms. in one hour, and the urine had nothing noteworthy. Deep roentgen ray therapy and nitrogen mustard gas were given without improvement. Finally the patient had chills and fever ranging to 102°F., occasionally to 104°F. and death occurred on September 18, 1950.

The main portion of the anatomic diagnosis of the complete necropsy are:

Marked diffusely infiltrative reticulum lympho-sarcoma of the lungs, and of the axillary, tracheobronchial, mesenteric, periaortic, biliary and inguinal lymph nodes;

Hyperemia of the lining of the larynx, trachea and bronchi;

Bilateral hydrothorax and focal fibrous pleuritis;

Marked emaciation;

Old surgical scars of the neck, left axilla and abdomen; etc.

The emaciated body of this adult white woman weighed 78 pounds. The lymph nodes in the right and the left axilla ranged to 4 cms. maximum diameter. Those along the common iliac vessels formed masses 5 by 3 by 3 cms. and were continuous with others about the abdominal aorta. The surfaces made by cutting these nodes had firm granular hyaline grey regions of tissue. Adventitious fibrous adhesions bound together bowel loops and other viscera of the peritoneum. The lining of the oesophagus distally had small superficial ulcers. Below the tracheal bifurcation the oesophagus was displaced to the right by a mass of lymph nodes 6.5 by 4 by 4.5 cms. (Figure 3). These were firm, elastic, grey mottled with carbon and had opaque hyaline regions 1 to 4 mms. dia. Similar firm lymph nodes were in front of the trachea. The lining of the trachea and main bronchi was hyperemic and edematous. At the hilum of the lungs the channel of the bronchi was narrowed by fibrous thickenings. The shrunken firm right lung weighed 630 gms., the similar left 770 gms. The pleura of the right lung was smooth except for torn ends of fibrous tissue. The lung tissues beneath were firm, cyanotic and mottled with grey tissues ranging to 2 cms. dia. Surfaces made by cutting the right lung had a diffuse grey consolidation, especially marked in the



Figure 3. Photograph of a large parabronchial lymph node. Note the masses of hyaline material, like boiled sago.

Figure 4. Photograph of a surface made by cutting the lower lobe of the left lung. Note the diffuse consolidation of the lung tissues and the discrete grey tumor nodules.

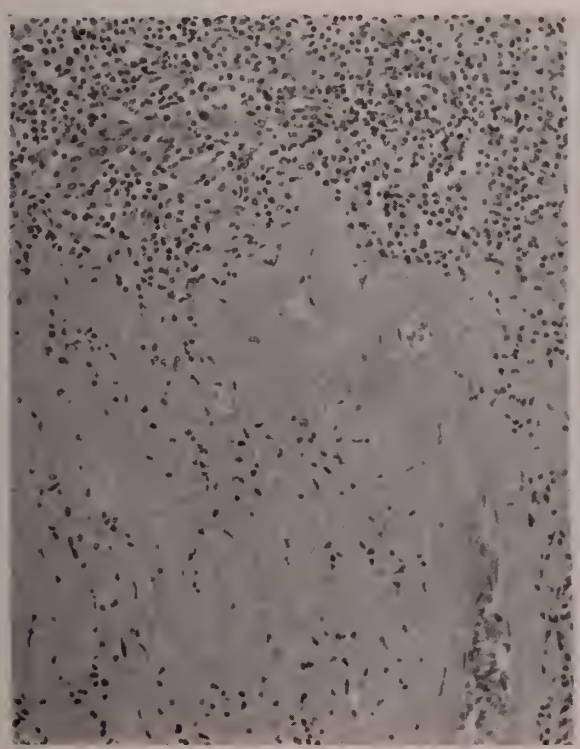


Figure 5. Photomicrograph illustrating the structure of the large hyaline masses in lymph nodes obtained during the necropsy. X-198

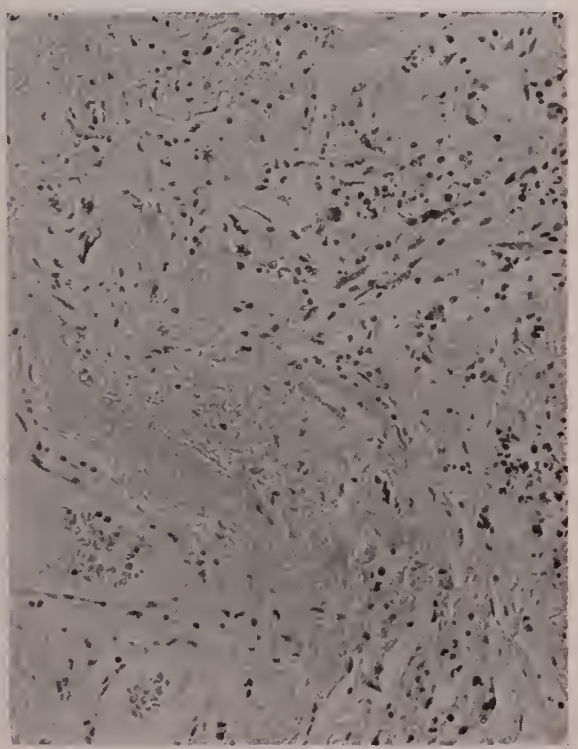


Figure 6. Photomicrograph illustrating the hyaline fibrous tissue replacement of the lung. X-198

upper lobe, but all portions were firm and noncrepitant. Scattered through the consolidated lung were small firm grey nodules ranging to 0.8 cm. dia. The pleura of the left lung also was roughened by torn fibrous adhesions. Surfaces made by cutting had a diffuse grey tissue infiltration, most marked in the upper lobe, and in the lower lobe was a discrete nodule of grey yellow tissue 4 by 3 by 3 cms. (Figure 4). Other similar but smaller nodules were scattered in the lung tissues. The lining of the bronchioles was hyperemic, that of the branches of the pulmonary veins and artery was smooth. The heart with 2 cms. each of aorta and pulmonary artery weighed 230 gms. There were no changes of the valves and myocardium. The right kidney weighed 90 and the left 70 gms. The liver weighed 1260 gms., the spleen 230 gms. and each had a few grey tubercles 1 to 2 mms. dia. The head and neck structures had no significant changes. The various lymph nodes had the changes observed in the biopsy tissues (Figure 5). The lungs had remarkable changes. Extensive portions were replaced by large masses of hyaline material with slits and oval spaces (Figure 6). These masses replaced or markedly distorted the alveolar tissues and bronchioles. The bronchioles and alveoli remaining contained leucocytic exudates and had flattened or columnar cells. Along the edge and in crevices of the hyaline masses were large reticulum cells with a pale acidophilic cytoplasm. Other alveolar spaces contained polynuclear leucocytes and mononuclear phagocytes or masses of fibroplastic tissues. Around the blood vessels of the Malpighian bodies of the spleen were large and small deposits of the hyaline material. The portions of bone marrow examined had no significant changes.

COMMENT

Kundrat many years ago recognized lymphosarcoma as a cancerous disease of lymph nodes and clearly distinguished this growth from other forms of lymph node enlargements. He stated that the lymphosarcomas arise in a group of lymph nodes and spread to other groups. Ghon and Roman specified the basic tissues in lymph nodes from which different forms of lymphosarcoma arise, the small and large lymphocytes, and the reticulo-endothelial cells. Sarcomas of reticulum cells, at first, were not recognized, and lymphosarcomas were classified as small or large lymphocytic. Later when the reticulum cell form received more general acceptance, the range of variation in the cell structure of these tumors was not fully understood. Thus, patients with enlarged lymph nodes which in biopsies were diagnosed lymphogranulomatosis (Hodgkin's Disease) had a subsequent clinical course like the lymphosarcoma. The lesions in the biopsied lymph nodes had eosinophilic leucocytes, large mononuclear cells with lobed nuclei, and a fibroplastic stroma, in brief, all of the details of tissue structure described for Hodgkin's Disease. However, careful search in these tissues revealed foci of large atypical cells, some in mitosis, which provided evidence of sarcomatous growth rather than granuloma tissues. The exudate cells thus had secondary significance. The structure of the reticulum cell lymphosarcomas therefore, ranges from cellular tumors with small amounts of stroma to growths with large amounts of hyaline fibrous tissues and with relatively few atypical reticulum cells, as in this patient.

ACUTE CASEOUS TUBERCULOUS PNEUMONIA

A white woman aged 64 years entered St. Luke's Hospital on August 19, 1950 in the care of Doctor W. Van Hazel. Concretions of the gallbladder had been removed in 1920 and afterwards she had had occasional attacks of pain in the right upper quadrant. These became more severe, more frequent and in July of 1950 the gallbladder was removed. She recovered promptly from the operation and in two weeks went home for further convalescence. At home she developed a productive cough, and had chills and fever. She returned to her local hospital and was treated with penicillin. A roentgen film revealed a lesion in her left lung. She did not improve and was transferred to St. Luke's Hospital. Her chief complaints were a productive cough of 2 or 3 weeks duration, anorexia and frequent emesis. She was a well developed woman without pain or distress. Her blood pressure was 130/80 mms. Hg. and her temperature was 98.8°F. The chest had diminished expansion on both sides and dullness to percussion on the left side. The left lung had a rough inspiratory and expiratory wheeze. The erythrocytes of the blood were 3,900,000 and the leucocytes 12,400 per cu. mm., the hemoglobin was

10.5 gms. per cent; 76 per cent of the leucocytes were neutrophilic, 15 were band forms, 5 were lymphocytes and 4 were monocytes. The urine had 50 mgms per cent of albumin. The sputum had many acid-fast bacilli. Her temperature rose to 102° to 104°F. and penicillin, streptomycin, para amino salicylic acid and aureomycin were given. The temperature dropped to near normal, but without clinical improvement. A roentgen film on September 1 disclosed extension of the lesion in the upper lobe of the left lung, and a mottling of the right considered to be miliary tuberculosis. Her respirations became shallow and rapid. Death occurred on September 3, 1950.

The essentials of the anatomic diagnosis of the necropsy (trunk) are:

Extensive caseous tuberculous pneumonia of the upper lobe of the left lung;

Miliary tuberculosis of the lungs, liver, spleen, ileum, rectum, uterus, and pericardium;

Fibrocaseous tuberculosis of the para bronchial lymph nodes;

Left hydrothorax; etc.

The body of this adult female weighed 135 pounds and was 154 cms. long. The right upper quadrant of the abdominal wall had an old cholecystectomy scar. The general nutrition of the body was good. Opposite the second left rib in the anterior mediastinum was a fibrocaseous lymph node 1.5 cms. in dia. The left pleural space contained 600 cc. of a clear yellow fluid, the right 500 cc. The epicardium was hyperemic and the posterior surface had many firm grey nodules 2 mms. in dia. The pericardial sac had similar nodules. The left parietal pleura was roughened by fibrous adhesions, the right had a few near the apex. The lymph nodes at the bifurcation of the trachea were enlarged and had fibrocaseous regions. The lining of the trachea and of the main bronchi was hyperemic. The lumen had a large amount of purulent exudate. The right lung weighed 650 gms. and had a smooth pleura. Surfaces made by cutting had hyperemic tissues with many grey and yellow

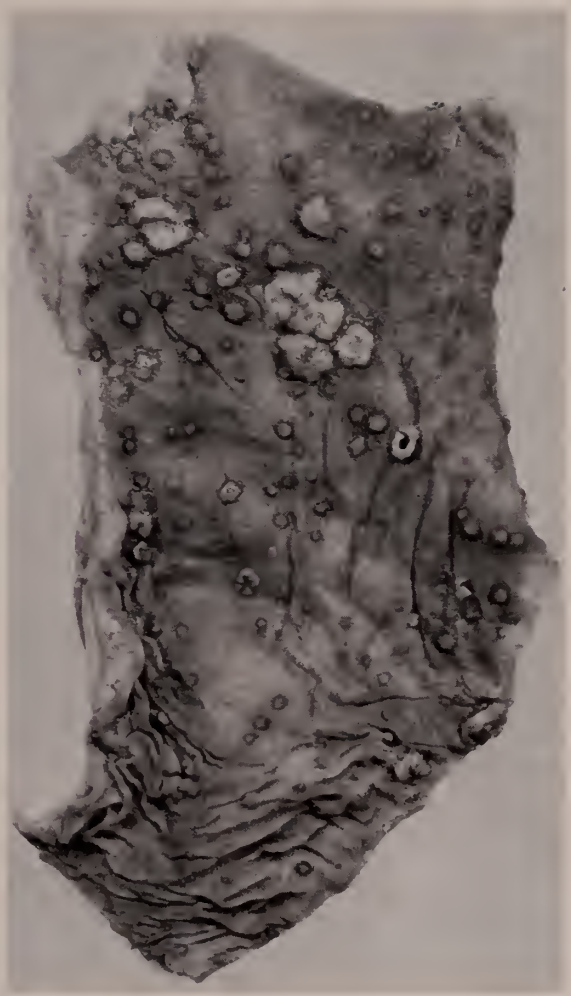


Figure 8. Photograph illustrating the multiple caseous and ulcerated tubercles in the lining of the rectum.

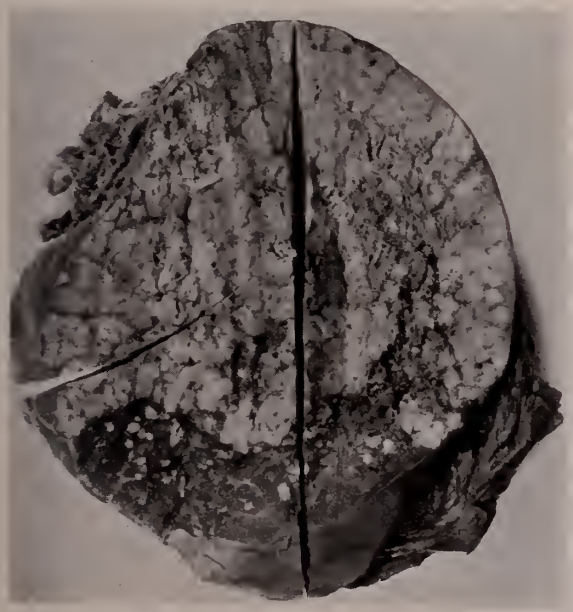


Figure 7. Photograph illustrating the extensive caseous tuberculous pneumonia of the upper lobe of the left lung.

nodules ranging to 5mms. dia. The left lung weighed 1510 gms. and the pleura of the upper lobe was rough and granular. Surfaces made by cutting the upper lobe had a grey consolidated region 13 by 15 by 8 cms. (Figure 7). The hyperemic lower lobe had many grey tubercles ranging to 4 mms. dia. Many acid-fast bacilli were found in caseous tissues of the upper lobe. The kidneys, ureters, and urinary bladder had nothing significant. The spleen weighed 270 gms. The tissues beneath the wrinkled capsule were dark red and had many grey tubercles 2 mms. in dia. The liver weighed 1750 gms., had a smooth capsule and the lobular tissues beneath had many yellow nodules 1 to 3 mms. in dia. The terminal 12 cms. of the ileum had numerous mucosal nodules 2 mms. in dia., some of them ulcerated. These extended into the caecum and, where coalesced, formed yellow plaques 1 by 2 cms. in dia. The appendix had been removed surgically. The lining of the rectum had many ulcerated nodules, 2 to 6 mms. in dia. (Figure 8). The myometrium of the uterus also had many grey tubercles ranging to 3 mms. dia.

COMMENT

Probably the most striking feature in this case is the short duration and the minimal clinical manifestations of the extensive tuberculosis which the postmortem examination of the body disclosed. The consolidated upper lobe of the left lung cast shadows in roentgen films which simulated those of a neoplasm. This extensive tuberculous pneumonia of the lung probably initiated the disseminated systemic miliary tuberculosis and the tuberculous enteritis, proctitis, and metritis.

SARCOMA OF THE RECTUM

A white male aged 64 years was admitted to St. Luke's Hospital in the care of Doctor Chester Coggeshall for the third time on September 15, 1950 and died two days later. His first admission in August of 1949 to the service of Doctor G. Pontius was for rectal bleeding of two years duration. Blood in the stools at first was associated with attacks of diarrhea, and later a sensation of incomplete evacuation followed defecation. Protoscopic examination disclosed a polypoid tumor of the rectum. A small piece removed for examination was diagnosed as sarcoma. On August 16, 1949 the sigmoid colon and rectum were removed by Doctor Pontius. A



Figure 9. Photograph illustrating the polypoid sarcoma of the rectum.

lobed, tan-brown polypoid tissue 8 cms. in dia. and 3 cms. thick was attached by a short pedicle 2.5 cms. in dia. at a level 5 cms. above the anal ring (Figure 9). The external surface was hyperemic and had shallow fissures. Another nodule 8 mms. in dia. was in the base of the pedicle. The regional lymph nodes were not involved. Surfaces made by cutting the polypoid mass had soft grey-red fibrillar tissues. These in histological preparations were highly cellular atypical mesoblastic tissues. Portions were elongated spindle cells with a little fibrillar cytoplasm, other places had large angulated cells in a supporting stroma and mingled with the spindle-shaped elements. Among the tumor cells were some in mitosis. The sarcoma tissues had infiltrations of polynuclear leucocytes and lymphocytes (Figure 10). A year later he was admitted again to St. Luke's Hospital because of cough, weakness and dyspnea. He then received radiation therapy to the chest for metastases of the

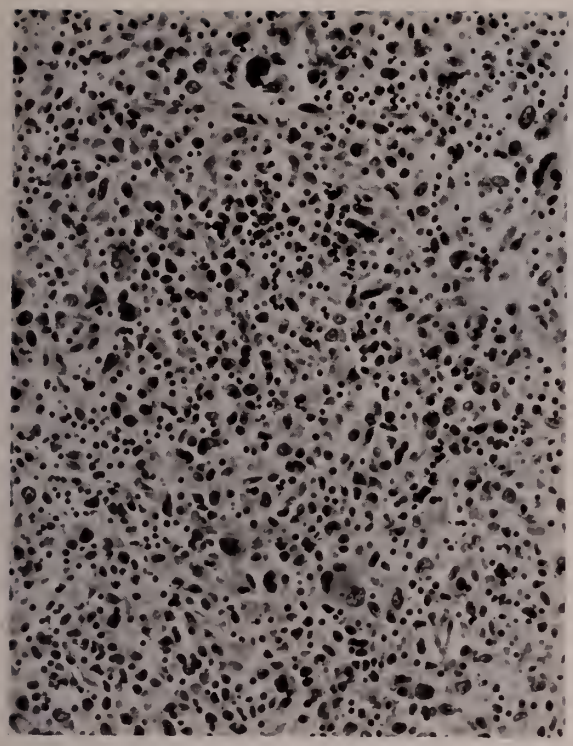


Figure 10. Photomicrograph illustrating the structure of the sarcoma tissues. X-198

lungs. When admitted finally on September 15, 1950 he was dyspnoeic and edematous, his temperature was 98.6°, the pulse was 90 and the respirations were 28 per minute. The erythrocytes of the blood were 3,000,000 and the leucocytes 11,000 per cu. mm. The non-protein nitrogen of the blood was 31 mgms per cent, the serum albumin was 2.31 and the globulin 3.47 gms. per cent. His respiratory distress increased despite oxygen, aminophyllin and digitalis. He suddenly became unresponsive, cyanotic and died.

The main portions of the anatomic diagnosis of the necropsy (trunk) are:

Sarcoma of the rectum — old surgical rectosigmoidectomy;

Metastatic sarcoma of the lungs and jejunum;

Old surgical colostomy of the abdomen;

Edema and emphysema of the lungs; etc.

The symmetrical body of this adult male weighed 135 pounds and was 166 cms. long. The abdomen had four healed surgical scars, one 7 cms. to the left of the umbilicus had a functional colostomy. The abdomen had nothing significant except surgical rectosigmoidectomy scars. There were no changes in the left pleural space, in the right were 300 ccs. of a pale yellow fluid with fibrin clots. The heart and the pericardium had no significant changes. Each lung weighed 670 gms. The pleura of both lungs was smooth and in each were many metastatic nodules of grey tumor tissues ranging to 5 cms. dia. (Figure 11). The lining of the proximal portion of the jejunum had a metastasis 2.5 cms. in dia. and 1.2 cms. thick (Figure 12). It extended to the serosa and the mucosal surface had a superficial ulcer. The viscera otherwise had nothing significant.

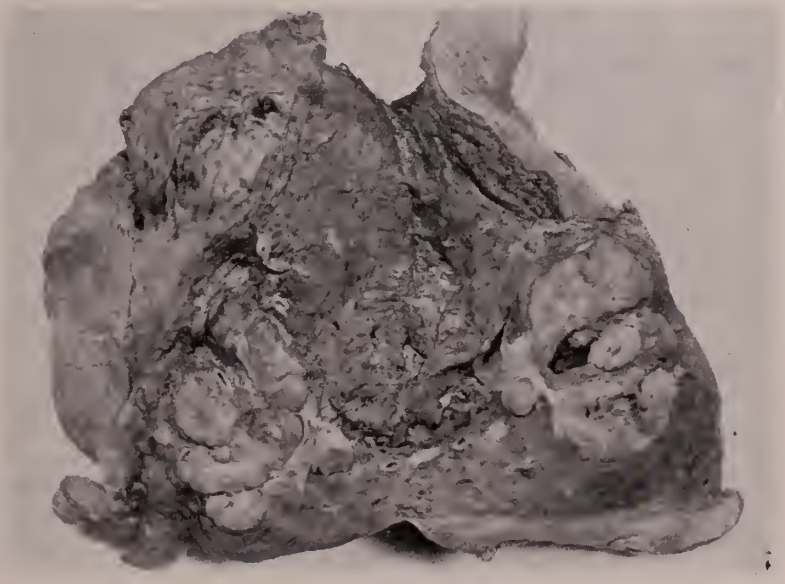


Figure 11. Photograph of a surface made by cutting the lungs and illustrating a large metastatic sarcoma nodule.

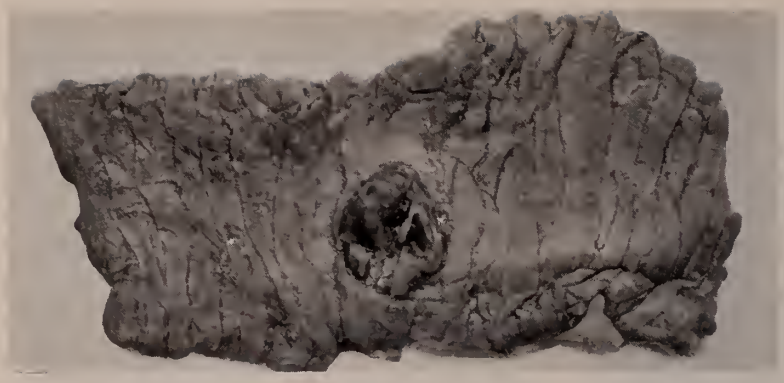


Figure 12. Photograph illustrating the metastatic sarcoma of the jejunum.

COMMENT

The usual cancerous tumors of the rectum are carcinomas; sarcomas are rare. The one observed in this patient arose from the lining and grew into the lumen. Despite this location, metastasis had occurred into the lungs at the time the growth was removed. The histologic structure of this sarcoma favors the opinion that the growth originated in the supporting and not in lymphoid tissues. The clinical course following surgical removal was brief, but according to clinical history, symptoms of the tumor had existed for at least two years before the surgical rectosigmoidectomy.

FEMALE FRIGIDITY

Women with problems involving frigidity seem to fall into two general groups: (1) those who seek the physician's help complaining of frigidity; (2) and those who present themselves with symptoms which appear totally unrelated to sex.

Among the first group are many young women, married a short time, who have found themselves either unable to have intercourse or to reach an orgasm. Opportunity to talk over the problem, and simple explanation and reassurance from the physician usually help these women to reach some kind of a superficially satisfactory adjustment.

The second group will usually be women who have been married several years and who will complain of severe headache, backache, alcoholism or some bizarre hysterical symptom. These patients will seldom consciously admit any sexual problem, but under hypnosis or sodium amytal will usually readily give a history of sexual maladjustment. Often it will be found that they have strong sexual desires which they are attempting to deny. Many of these patients too can be relieved by simple psychotherapy. *Excerpt: Human Behaviour: Importance of Frigidity, Thomas F. Coates, Jr., M.D., Richmond, Southern M. and Surg., May,* 1951.

COUNCIL MEETING MINUTES

The regular meeting of the Council held in Chicago on Sunday, August 5, was attended by the following: Chairman Blair, White, Sweeney, Maloney, Muller, Camp, Lundholm, Greening, Stone, Oldfield, Vaughn, Reichert, Peairs, Newcomb, Hulick, English, Fullerton, Montgomery, Hamilton, Hedge, Hopkins, Hutton, Coleman, Cross, George Hellmuth, R. H. Hayes, Wayne Slaughter, Limarzi, Neal, Leary and Frances Zimmer. Note from Harker who has been ill reporting satisfactory progress and expects to attend next meeting. Minutes of last meeting approved. Secretary discussed financial statement, and referred to his report mailed in advance of meeting to members. Chairman stated individual items in report would be acted upon under new business. Blair announced new personnel for several committees.

WHITE gave report as President, telling of his attending A. M. A. meeting in Atlantic City, and spending some time discussing mutual problems and projects in other societies, as given by their presidents. Recommended that medical schools, employment agencies, the press, schools, and other organizations and groups be informed that Secretary's office act as clearing house for communities seeking physicians and physicians seeking locations. Also believes same information should be given to pharmaceutical organizations whose salesmen know much concerning these needs. Recommends that occasional meetings be held with representatives of the press, radio, TV, and Hospital Association personnel; to consider ways and means for a better spirit of cooperation between these groups.

WHITE recommends that component societies select someone to counsel with prospective medical students relative to medical schools and medical education, hospitalization and locations. Believes more physicians should become interested in psychiatry and psychosomatic medicine, especially when we note the number of people in the several state hospitals needing expert care.

SWEENEY, as President-Elect commented on some current problems, in a short report. STONE reported recommendation of the Executive Committee that the Council sponsor the publication of the Auxiliary Bulletin for the current fiscal year. Approved by proper action. Several Councilors reported problems and functions in their respective districts. Councilor O'Neill on vacation, wired his regrets at missing the meeting; unable to obtain plane reservations from Traverse City, Michigan to get to Chicago in time.

VAUGHN told of talks being made at Loyola to upper classmen on medical organization, and student A. M. A.: also told of C. M. S. endeavoring to get more intern members. Believes this should be done in all schools and for interns. A motion was unanimously approved that medical schools be urged to schedule talks on organized medicine and its work. HAMILTON told of the student work the A. M. A. is doing, believing it can be started in the freshman year; with 28,000 students in the country, believes this should be encouraged in Illinois as elsewhere.

BLAIR stated that the Committee on Medical Service and Public Relations will be asked to aid in the work among students. Blair told of two recent meetings in his district, at which he presented the usual certificate and emblem; told of the interest and attendance at the meetings. Urged Councilors to tell members in counties with no component society that wives of physicians may join the Auxiliary as "members at large". Several Councilors told of problems in their respective districts, and their solution, or what is being done to alleviate them.

HOPKINS reported as chairman of the Committee on Medical Service and Public Relations. Referred to city of Savanna having a holiday, Wednesday, August 8, to honor a highly respected citizen, Dr. Joseph B. Schreiter, who has practiced 55 years. Committee recommends that the State Society be officially represented by the President, Chairman of the Council, Secretary and Councilor Lundholm of that district. By proper action it was unanimously voted that the officers as named be the official representatives at this interesting meeting, at which Andy Hall is to be the principal speaker. Referred to some other meetings at which his committee recommends the society be officially represented. Favorable action was taken on these requests. Referred to Public Relation meetings in various parts of the state, which have been arranged for fall months; these not to interfere with post graduate conferences, or other official meetings or conferences.

LEARY, as Director of Public Relations, told of the plans for a Society booth at the Illinois State Fair in Springfield. This is to be operated by the Auxiliary to the Sangamon County Medical Society. Hopkins believes Leary should go to Springfield to arrange and be present at the opening on the first day of the fair. Action taken approving the request. NEAL discussed some legislation approved at the recent legislative session in Illinois. Will have his report ready for distribution soon.

HEDGE told of recent conferences of the Interprofessional Committee, which has been functioning principally so far in perfecting its organization, developing Constitution and By-Laws. Chairman shall serve one year only, and chairmanship shall rotate among the participating groups. Later in this meeting WAYNE SLAUGHTER, Chairman of Society committee, came in and continued the report, supplementing remarks of Hedge, who had attended the meetings.

COLEMAN reported as Chairman of the Advisory Committee to the Illinois Public Aid Commission. Told of meeting of committee with officials of the I. P. A. C. the previous evening, and what had been accomplished at this conference. Three visitors were present, as it is the custom to invite at least two members of county advisory committees to be present, as well as one member of the Council. Told of some recent increases in medical fees for services to I. P. A. C. clients. It is now believed that direct payment to physicians will begin about October 1.

HAYES reported as Chairman of the Committee on Medical Benevolence, reporting on actions taken and payments made to beneficiaries by the Committee. Recommended some changes in current method of approving applicants for benefits, in keeping with other organizations. Committee to meet in near future to discuss some minor changes in procedure, which will be reported at the next meeting of the Council.

HUTTON told of a recent meeting of the Editorial Board, at which time some 68 papers received for publication had been reviewed. It was the usual procedure to review some papers during the meeting, then allocate others to individual members, or occasionally have several give their recommendations relative to the approval of papers. It has been the policy in considering some highly technical papers to return same to the writer with the request that they be submitted to journals considering only that specialty. Referred to the necessity of having shorter papers so that more can be published in each journal issue. Stated that approval was given to regular publication of minutes of Council meetings, as many members desire this information. Told why they have not been published during the past year, but will be resumed in the September issue of the Journal. Hutton told of the discussion by the Editorial Board of the publication of the transactions of the House of Delegates, now being published in the July and August issues of the Journal. Board recommends this be changed to publishing same as a supplement, then members will have the transactions in one booklet instead of in two journals. After some discussion the Secretary was asked to investigate the cost of separate publication of the minutes, and report at the next meeting in October.

LIMARZI reported as Chairman of the Committee on Scientific Service, telling of some meetings to be serviced in the fall. Purposes to have an early meeting of his committee. Would like to have speakers on the subject of nutrition who can fill some requests recently received. Will ask Committee on Nutrition to assist in listing speakers and subjects.

LIMARZI also referred to work of Committee on Blood Banks of which he is chairman. There are now four blood bank committees in Cook County, and believes they should work jointly in getting data from the various hospitals, rather than to submit four different questionnaire forms. Believes better results may be obtained through one survey and requests Council approval for adoption of plan as recommended. By proper action the combined project survey as proposed by Limarizi was approved. There was considerable discussion on the subject of blood banks. Lundholm told of the Rockford area developing a "walking blood bank", listing citizens according to their blood types, having names and addresses recorded so that any of them may be called in an emergency to donate blood, of the desired type. There are now some 50,000 members in the Rockford area. Waukegan now developing a similar set up, which will permit an exchange of rare types in the respective districts.

SLAUGHTER supplemented the report previously given by Hedge on the Interprofessional Committee giving more details on their accomplishments, and what they propose to do. He asks Council approval of their actions, and will have a complete report for the next meeting.

HELLMUTH reported as chairman of the Post Graduate Committee, telling of a recent meeting of the committee, and handing out mimeographed copies of their proposed conferences to be conducted during the fiscal year. Told of the necessity of using greater care in scheduling the conferences, to be sure there is less conflict with other meetings, as has been too often the case in recent conferences. Some new ideas were presented relative to the length of the conferences, number of speakers to be scheduled and types of

presentations to be made. After much discussion it was decided that Hellmuth would meet following the close of the Council meeting, with the Executive Committee, and members of the Post Graduate Committee, to discuss the proposal, and adopt a definite plan. This was done, and it was proposed that a trial program be arranged for September, to be reported in more detail later.

NEWCOMB reported for Hoyt as Chairman of Committee on Nutrition; meeting held in Chicago June 22 to coincide with Annual Convention on Nutrition and Health of the Friends of the Land. Committee presents certain recommendations for Council approval. Meeting with Deans of Medical Schools in Chicago in the effort to get improvements in curricula and research departments in field of nutrition; endeavor to impress upon physician's importance of subjects of soil fertility, nutrition and health at meetings, including post graduate conferences, and recommending publication of articles on these subjects in Illinois Medical Journal; cooperation with lay committees on nutrition and health, and making qualified speakers on the subject available through the facilities of the Educational Committee. Also recommends that an outstanding speaker be selected to make the address on nutrition and health at the next annual dinner, during the Annual Meeting. The report as presented, was approved by the Council.

The Council members from Chicago were asked by the Chairman to suggest the member to be selected as the General Chairman, Committee on Arrangements for the 1952 annual meeting. This to be done within the next week, if possible. Date of the 1953 annual meeting was considered, and as the A.M.A. is scheduled to meet that year in New York City and on June 1-5, it was deemed advisable to set date for the Society Annual Meeting earlier than usual in May. By proper action the date set is May 12-14, 1953, place, Chicago.

CROSS, as Director, State Department of Public Health, told of recent actions taken by the state legislature pertain to the subject of health. These to be published later in the Journal. Handed out mimeographed report with factual data concerning new hospitals constructed under the Hospital Construction Act. Also discussed the present poliomyelitis situation in Illinois and the controversial subject of immunizations during the polio season.

BLAIR reported as Chairman of the Educational Committee: TV Health Talk was off the air from April 10 until July 3, and is now being presented over Station WGN-TV at 7:30 P.M., Tuesday of each week. Tells of investigations being made by other societies and thein interest in the programs which have been presented under the auspices of his committee during the past two years. Referred also to recent and proposed radio health talks, as arranged by his committee.

SECRETARY told of proposal to send an informative letter to new members reported to his office, and a package of data including Constitution and By-Laws, Code of Medical Ethics, A.M.A. Handbook, Veterans Administration Home Town Care Program, application for participation and copy of fee schedules; the booklet "Doctor and Horses", telling of the need of physicians and nurses, and data concerning the Illinois State Medical Society, Illinois Agricultural Association Joint Student Loan Fund, information on Illinois plan for prepayment medical and surgical care, and the Illinois Medical Service, now operating in most Illinois counties. This can be modified if desired, and would be an excellent indoctrination for new members. By proper action the proposal was approved and will be started soon from the Secretary's office.

Several actions were taken on matters presented by the Council Executive Committee, as presented by Councilor F. Lee Stone. Several State and Nation Wide organizations requested a medical advisor as a member of their respective Advisory Committees, each of which was favorably acted upon. A list of applicants for Emeritus, Past Service and Retired Membership classifications were presented, and as they had been so recommended by the local component societies; all were approved as presented.

Meeting adjourned at 2:30 P.M.

Harold M. Camp, M.D.
Secretary

NEWS OF THE STATE



CARROLL

Carroll County Honors Its Veteran Physician.—Carroll County's 19,000 people, with substantial help from nearby counties in Illinois and Iowa, turned out August 8 to honor Dr. Joseph B. Schreiter of Savanna, who has been "Doc" to them for fifty-five years.

The party began with a parade at 11:30 a.m., moved on to a picnic at noon in Old Mill Park, and closed with oratory and the bestowal of various surprise honors on the 76-year old physician. Every shop in town closed between noon and 2 p.m., the American Legion band led the parade, and the Lions Club, which started the idea, expressed on behalf of the community just how much they all appreciate "Doc's" lifetime of serivce.

A general invitation was issued to all the 4,000 babies over whose delivery Dr. Schreiter has presided in his 55 years of practice. Wayne King, famous band leader, best known perhaps of all "Doc's" crop, also attended.

The Illinois State Medical Society, to whose Fifty Year Club Dr. Schreiter belongs, sent Dr. Andy Hall of Mt. Vernon, 86-year old veteran who was chosen the outstanding general practitioner of the nation for 1950 by the American Medical Association, as principal speaker for the party.

Also representing the organized medicine of the state were Dr. C. Paul White of Kewanee, president of the Illinois State Medical Society, Dr. Harold M. Camp of Monmouth, its secretary; Dr. Charles P. Blair of Monmouth, chairmen of its council; and Dr. Joseph S. Lundholm of Rockford, state councilor. Many other physicians, old friends of the veteran, joined the 16 other members of the Carroll County Medical Society in honoring him.

Dr. Schreiter was born in Darlington, Wis., January 4, 1875, and was graduated from Rush Medical College, Chicago, in 1896, and immediately settled in Savanna. He married Miss Bess Beaver of Mt. Carroll and they have one son, Jesse, a mathematician at the University of Ohio.

Dr. Schreiter was elected coroner in 1903 and still serves in that post, having been re-elected eleven times, which is believed to be a record. In World War I he served 22 months in France with an Army hospital and later became the Savanna American Legion's first commander. He is chief of staff of the Savanna City Hospital and was formerly the Burlington Railroad's physician for the county and surgeon to the big federal ordnance plant.

Dr. Schreiter is vice-president of the Savanna Savings, Building and Loan association and of the National Bank of Savanna. He is a member of Sigma Chi and of numerous lodges and medical societies. Despite his age and many activities, he still takes care of a substantial practice, making house calls and keeping evening office hours, though he no longer does major surgery.

CHAMPAIGN

Society News.—At a joint meeting of the Champaign County Medical and Dental Societies recently, William Neiswonger and Robert W. Mayer, members of the staff of the University of Illinois College of Commerce, discussed "Personal Financial Management for the Professional Man."

CLINTON

Physician Honored.—Citizens in the town of Hoffman gathered together to give honor to Dr. Andrew Fischer, July 29, in recognition of his forty-five years of practice in their community. To commemorate the occasion, a plaque was presented to Dr. Fischer.

COOK

James Campbell Goes to New York.—Dr. James Allan Campbell, assistant professor of medicine, University of Illinois College of Medicine, has been appointed dean of Albany Medical College, succeeding Dr. R. S. Cunningham.

Dr. Herrick Honored.—Dr. James B. Herrick, Chicago, was among three persons honored with Gold Heart awards at a meeting in Atlantic City by the American Heart Association. Dr. Louis N. Katz, Chicago, president of the association, in making the presentation referred to Dr. Herrick as "the most distinguished living student of the cardiovascular disorders."

Dr. O'Brien Heads Department of Medicine.—Dr. George F. O'Brien has been appointed chairman of the department of medicine at Stritch School of Medicine of Loyola University. Formerly associate clinical professor of the department, Dr. O'Brien fills the vacancy caused by the death of the late Dr. Italo Volini.

Francis Mullin Heads Committee on Internships.—Francis J. Mullin, Ph.D., dean of the Chicago Medical School, has been named charman of the newly formed National Inter-Association Committee on Interships. This is a central clearing body that will put into operation a plan proposed by Dean Mullin for arranging internship appointments by matching perference of students with preference of hospitals. The committee is composed of representatives from the American Hospital Association, American Protestant Hospital Association, the Catholic Hospital Association, Association of American Medical Colleges, Council on Medical Education and Hospitals of the American Medical Association, and liaison members from the Air Force, Navy, Public Health Service and Veterans Administration which are the federal agencies offering internships.

Loyal Davis to Give Lecture at Oxford.—Dr. Loyal Davis, professor of surgery and chairman of the department at Northwestern University's Medical School, has been selected to give the Earl of Litchfield lecture at Oxford University October 10. Dr. Davis will talk on "The Physiological Principals Underlying the Treatment of High Diastolic Hypertension by Thiocyanates and Sympathectomy."

Named the first Grunow Professor of Surgery at the University, Dr. Davis is a graduate of Knox College, Galesburg, and of the Northwestern Medical School. He has been a member of the Northwestern faculty since 1925 and chairman of the department of surgery at the University since 1932. He is a regent of the American College of Surgeons.

Woman Physician Heads Health Service.—The appointment of Dr. Evelyn Adams to the directorship of the employees health service at the University of Chicago marks the first time a woman has held this position at the Midway university. Announcement of the appointment was made by Dr. Lowell T. Coggeshall, dean of the division of biological sciences. A 1949 graduate of the University of Chicago medical school, Dr. Adams interned at the university clinics. Last year she held a surgical residency at the University of Iowa. Dr. Adams also received her bachelor of science degree from Chicago and is a member of Phi Beta Kappa. Born in Georgetown, Illinois, she attended schools in Lenoir City, Tennessee.

New Abbott Professors.—Four members of the faculty of Northwestern University's Medical School have been appointed Abbott Professors for the academic year 1951-52.

The four men will engage in medical research made possible by a $1,500,000 gift Northwestern received in 1939 from the estate of the late Clara A. Abbott, widow of Dr. Wallace C. Abbott, founder of Abbott Laboratories in North Chicago.

Named Abbott Professors were Dr. Carl Dragstedt, professor and chairman of the Department of Pharmacology; Dr. Henry Bull, professor in the Department of Chemistry; Dr. Fred Grodins, professor in the Department of Physiology; and Dr. E. Albert Zeller, associate professor in the Department of Chemistry.

Carroll Birch Goes to India.—Dr. Carroll L. Birch, professor of medicine at the University of Illinois, has been appointed dean of the Lady Hardinge Medical College for Women at New Delhi, India.

Dr. Birch left Chicago in August. She will remain in New Delhi for a period of one year.

Lady Hardinge Medical College for Women is the only Indian medical institution for the training of women. The school which is endowed by a British noblewoman is more than 100 years old.

Dr. Birch is assuming the position at the New Delhi school at the request of the Department of State, which has received requests from Near Eastern and other Asiatic countries for technical assistance in the health and medical sciences.

Her specific assignment well be to train a replacement to take over the duties of dean of the college. She also will prepare recommendations for the reorganizations of the teaching methods and curricula of the school in order to raise its standards to meet those of modern medical educational institutions.

The experience gained in India is expected to add to Dr. Birch's knowledge of tropical medicine and to enrich the course in that subject which is currently offered by the University of Illinois College of Medicine.

Dr. Birch, a specialist in blood diseases and tropical medicine, has made previous visits to Africa, the Central American countries, Puerto Rico, and Europe for research studies in her specialty.

Personal.—Dr. James P. Simonds, professor emeritus of pathology and former chairman of the department, Northwestern University Medical School was recently awarded an honorary degree of laws by Baylor University, Waco, Tex. The degree was presented to Dr. Simonds on the fiftieth anniversary of his graduation at Baylor.—Roman L. Haremski, Ph.D., has been appointed director of the Division of Child Welfare of the Illinois Department of Public Welfare, succeeding Miss Ruth Dana, acting superintendent since March, 1950, resigned.—Dr. Jules H. Masserman, associate professor of nervous and mental diseases, Northwestern University Medical School, and scientific director, National Foundation for Psychiatric Research, has been appointed consultant to the secretariat of the United Nations and designated by the World Health Organization to present a series of lectures at various universities throughout Europe and Scandinavia in October and November of this year. During his stay in England, Dr. Masserman will also address the Britain Royal Society on his research studies and their significance to dynamic concepts of personal and social behavior.

Special Society Elections.—At a recent meeting of the Chicago Neurological Society the following officers were elected: Dr. John Martin, president; Dr. Hugh T. Carmichael, vice president; Dr. Joseph A. Luhan, councilor, and Dr. Leo A. Kaplan, secretary.——Dr. Charles K. Petter, Waukegan, was recently elected president of the Illinois Chapter of the American College of Chest Physicians. Other officers are Dr. William J. Bryan, Rockford; and Dr. Abel Froman, Chicago, secretary-treasurer.

Student Prizes Awarded.—Robert J. Maganini, third-year medical student, has been awarded the 1951 Leo F. Miller Prize at the University of Illinois College of Medicine for his presentation of an essay in the field of orthopaedic surgery.

Awarding of the prize, which carries a $50 stipend, was anounced by Dr. Fremont A. Chandler, professor and head of the department of orthopaedic surgery. The prize-winning essay was entitled "Solitary Unicameral Bone Cyst."

A second place award of $15 was presented to William S. Johnson for his paper on "Traumatic Injuries of the Menisci." George A. Hart received the third place prize of $10 for his essay on "Spondylolisthesis."

Honorable mention was awarded to Hyman L. Cohen, Martin E. Blazina, and Frank L. Meyer.

Grants for Research.—Northwestern University has received a $38,000 grant from the Office of Naval Research for the study and development of materials and techniques to aid in the neuropsychiatric selection of Navy personnel. The project, which was to have begun September 1, will be under the direction of Dr. William A. Hunt, Northwestern professor of psychology. Associated with him will be Dr. Cecil L. Wittson, professor of neurology and psychiatry at the Medical College of the University of Nebraska. The two research workers will seek to devise new techniques to determine what men will not be able to adjust to military service, and also to aid marginal men in making the adjustment.—Three Chicago organizations and companies have awarded grants to the University of Illinois College of Medicine in support of research investigations. The grants are as follows:

Asthmatic Children's Aid, $10,000, in support of histochemical and immunological studies to be conducted under the supervision of Dr. B. Z. Rappaport.

Swift and Company, $8,250, for a study of the relationship of bile to cholesterol to be conducted under the direction of Dr. A. C. Ivy.

G. D. Searle and Company, $5,540, in support of a study of the effect of banthine on the motility of the small and large intestines which is being undertaken by Dr. Michael H. Streicher.—Three new grants have been received by the University of Illinois in support of research investigations. These grants are as follows:

Bristol Laboratories, Syracuse, N. Y., $2,500, for the establishment of a research fellowship under the supervision of Dr. S. B. Binkley.

Winthrop-Stearns, Inc., New York City, $2,400, for a study involving the screening and the investigation of new anesthetic drugs. Dr. Max S. Sadove will conduct this study.

The Upjohn Company, Kalamazoo, Mich., $1,000, representing a new grant entitled "Intravenous Gelatin" to be supervisd by Dr. C. W. Vermeulen. —Four subsidiary scholarships of $10,000 each have been awarded by the David, Josephine and Winfield Baird Foundation, Inc., of New York City to the Chicago Medical School this year, according to an announcement issued by President John J. Sheinin.

A subsidiary scholarship, President Sheinin explained, makes up the difference between the amount a student pays in tuition and what the school must expend for his four years of medical training.—Five subsidiary scholarships of $10,000 each, making a total of $50,000 for the five year period 1950-54, have been given to the School by Isadore Leviton, President of the Leviton Manufacturing Co. of Brooklyn, N. Y.—A research grant of $5,635 has been made by the Public Health Service of the Federal Security Agency to Dr. Harold Koenig, assistant professor of gross anatomy, Chicago Medical School. Dr. Koenig's research project is a morphologic and quantitative study of neucleoprotein in developing nerve cells grown in tissue culture.—Grants for research totaling more than $18,000 have recently been received by the Chicago Medical School. The Eli Lilly Research Laboratories gave $6,000 for work in experimental diabetes under the direction of Dr. Piero P. Foa, associate professor of physiology and pharmacology. The Chicago Heart Association, for the year July 1, 1951 to June 30, 1952, made grants of $2,000 and $6,800 for studies to be conducted under the direc-

tion of Dr. Aldo A. Luisada, program director of cardiology and assistant professor of medicine; and $4,000 for research directed by Dr. George J. Scheff, associate professor of microbiology.

Biophysical Aspects of Virology.—A series of lectures and demonstrations in the biophysical aspects of virology will be given by Dr. Max A. Lauffer, professor of biophysics at the University of Pittsburgh, on Sept. 20, 21, and 22. These lectures are part of the Gehrmann lecture series sponsored by the Department of Bacteriology of the University of Illinois College of Medicine.

The following program will be presented:

Thursday, Sept. 20.

Lecture: Ultracentrifugation. 1:00 p.m., University of Chicago, Abbott Hall, 947 E. 58th St.

Demonstration: The use of centrifugation for preparation and characterization of viruses. 3.00 p.m., Abbott Hall.

Friday, Sept. 21.

Lecture: Electrophoresis. 1:00 p.m., North amphitheatre, Presbyterian Hospital, 1753 W. Congress St.

Demonstration: The use of electrophoresis for purification and characterization of viruses. 3:00 p.m., Presbyterian Hospital.

Saturday, Sept. 22.

Lecture: Electron Microscopy. 9:30 a.m., University of Illinois Research and Educational Hospitals, 1835 W. Polk St.

Demonstration: The use of electron microscopy in the study of viruses. 11:00 a.m., Room 342, University of Illinois Dental-Medical-Pharmacy Building, 1853 W. Polk St.

All interested are invited to attend the lectures. Because of space restrictions, however, the demonstrations must be limited to 20. All who wish to attend the lectures may register by writing to Dr. J. E. Kempf, Department of Bacteriology, University of Illinois, 808 S. Wood St., Chicago 12, Illinois, before Sept. 15.

Illinois Sole Administrator of Neuropsychiatric Institute.—Through a newly enacted bill, the Illinois Neuropsychiatric Institute in Chicago has been transferred from the State Department of Public Welfare to the University of Illinois. The Illinois Neuropsychiatric Institute formerly was operated jointly by the two institutions. Professional services were in charge of Dr. Eric Oldberg and Dr. F. J. Gerty of the University of Illinois College of Medicine. Funds for nursing services were appropriated to and paid for by the State Department of Public Welfare. Funds for the physical plant operation of maintenance and for food service were appropriated to the Department, but the services were provided by the University.

Under the new plan of operation, all activities and operations of the Illinois Neuropsychiatric Institute are vested in the University of Illinois. This change was recommended by the Schaefer Commission on State Reorganization and was concurred in by both the University of Illinois and the State Department of Public Welfare. In the University of Illinois Neuropsychiatric Institute as it is now constituted, Dr. Eric Oldberg will serve as Director of the Division of Neurology and Neurological Surgery and Dr. Francis J. Gerty as Director of the Division of Psychiatry.

The plan will facilitate professional administration of the activities, and greatly simplify business procedures in the University, the Department, and all state fiscal offices.

The purpose of the Institute, as stated by the University of Illinois Board of Trustees, is to act as liaison between the Illinois State Mental Health Service and the University of Illinois in a cooperative effort to improve the quality of the medical personnel dealing with patients committed to their care and to seek new and improved methods of treatment for the afflictions from which they suffer.

The operation of the State Psychopathic Institute and the Pathological Laboratory, which are housed in the Illinois Neuropsychiatric Institute, will remain in the State Department of Public Welfare. Dr. Percival Bailey, professor of neurology and neurological surgery at the University, who previously served as executive officer of the institute for the State Department of Public Welfare, will be in charge of these activities for the Department. The University, however, will assume the physical operation of the space used by these activities.

The bill which has been passed by the General Assembly includes an appropriation of $1,405,700 to the University of Illinois for the operation and maintenance of the Institute for the biennium beginning July 1, 1951.

In 1941, the other units of the Research and Educational Hospitals were transferred from the State Department of Public Welfare to the University of Illinois. Exceptions were the Illinois Neuropsychiatric Institute and the Institute for Juvenile Research. The latter continues in the Department.

DE KALB

Physician Honored.—The medical staff and friends of the Sycamore Municipal Hospital held a dinner August 30 in honor of Dr. John W. Ovitz in recognition of his thirty years of outstanding medical service to the community. The dinner was held at the Kishwaukee Country Club in DeKalb.

DE WITT

Personal.—Dr. P. C. Sturmon, was elected president of the DeWitt-Piatt Bi-County board of health at a recent meeting.

JEFFERSON

Dr. Poole Honored.—Dr. C. J. Poole, seventy-seven year old retired Mount Vernon physician, was recently inducted into the Fifty Year Club of the Illinois State Medical Society at a staff

meeting of Good Samaritan Hospital. The presentation of the certificate and emblem signifying membership in the Club was made by Dr. Andy Hall.

KANKAKEE

Society News.—Dr. O. A. Phipps, Manteno, president of the Kankakee County Medical Society, was responsible for scheduling the following programs for the society recently: Dr. Irwin Callen, Chicago, "Newer Developments in Coronary Disease"; A. R. Goldfarb, Ph.D., Chicago, "Medical Aspects of Atomic Blast"; Dr. Wright Adams, Chicago, "Cardiovascular Diseases with Special Emphasis on the Medical Aspect of Hypertension"; Mr. Harry W. Ginty, Fort Wayne, Ind., "What is the Law?"; and Dr. Philip Thorek, Chicago, "Jaundice."

KNOX

Society News.—At a recent meeting of the Knox County Medical Society in Galesburg, Dr. Philip Thorek, Chicago, spoke on "Jaundice."

Fifty Year Member.—Dr. E. N. Nash, who has been practicing in Galesburg for forty-seven years, was inducted into the membership of the Fifty Year Club of the Illinois State Medical Society at a meeting of the Knox County Medical Society in July. The presentation of the certificate and pin denoting membership was made by Dr. Charles P. Blair, Monmouth, Chairman of the Council of the Illinois State Medical Society. Prior to opening practice in Galesburg, Dr. Nash, who graduated at Rush Medical College, practiced in Oak Park.

ROCK ISLAND

Society News.—"The Doctor and His Estate" was the title of a talk given by Mr. Henry C. Black, Battle Creek, Mich., before the Rock Island County Medical Society recently.

SANGAMON

Personal.—Mr. Frank R. Shank was recently named executive director of the Memorial Hospital of Springfield, filling the vacancy created by the death of Victor S. Lindberg.

ST. CLAIR

Society News.—At a recent buffet dinner meeting of the St. Clair County Medical Society and its auxiliary, Doctors Francis Bihss, Norman Shippey and Walter Broker discussed "Unusual Chest Pathology" and "The Present Day Management of Pulmonary Tuberculosis." At a subsequent meeting, the society held its annual picnic and barbecue, always a popular event with the membership.

GENERAL

Hospitals Extend Facilities for Polio.—Facilities of 128 Illinois hospitals have been pledged for diagnosis or treatment of polio patients this summer, Dr. Roland R. Cross, state director of public health, announced recently.

"This is a culmination of many years of effort on the part of various public health agencies to enlist the participation of administrators of general hospitals in admitting polio patients," Dr. Cross said.

In the past, he explained, many hospitals have been reluctant to admit polio victims for fear of spread of this contagious disease to other patients.

He praised the Illinois Polio Planning Committee for stimulating state-wide recognition of the role general hospitals can assume in fighting polio and caring for its victims. This committee was formed a little more than a year ago on the recommendation of Governor Adlai E. Stevenson.

The network of hospitals to care for polio patients in event of a serious outbreak is based upon a survey which was made by this committee to determine possible needs at the peak of a polio season. The committee also has conducted a series of district meetings to inform hospital personnel in methods of caring for polio patients so that other patients will not be exposed to the disease.

Of the 128 hospitals pledging help to polio victims, 66 will provide diagnostic facilities only; 34 will provide diagnostic service and treatment; 12 will give diagnosis, treatment and rehabilitation care and 16 will provide convalescent and rehabilitation care.

New Officers of Medical Research.— Dr. Anton J. Carlson, professor emeritus of physiology, University of Chicago School of Medicine, was re-elected president, and Dr. Andrew C. Ivy, vice president and head of the professional colleges of the University of Illinois, vice president, of the Illinois Society for Medical Research.

Dr. N. R. Brewer, superintendent of animal quarters, University of Chicago was elected secretary, and Dr. C. C. Pfeiffer, head of the department of pharmacology, University of Illinois, was elected treasurer.

The Society, an affiliate of the National Society for Medical Research, is planning to expand its membership and activities. The membership and fund raising committee has drafted plans for a larger and wider membership and for a regular individual and institutional contribution program. A widespread public education program is being devised and committees have been appointed to carry out specific portions of the program of the Society.

Essay Award.—The Board of Regents of the American College of Chest Physicians offers a cash prize award of two hundred fifty dollars to be given annually for the best original contribution, preferably by a young investigator, on any phase relating to chest disease. The prize is open to contestants of other countries as well as those residing in the United States. The winning contribution will be selected by a board of impartial judges and the award, together with a certificate of merit, will be made at the forthcoming annual

meeting of the College. Second and third prize certificates will also be awarded. All manuscripts submitted become the property of the American College of Chest Physicians and will be referred to the Editorial Board of the College journal, "Diseases of the Chest," for consideration. The College reserves the right to invite the winner to present his contribution at the annual meeting. Contestants are advised to study the format of "Diseases of the Chest" as to length, form and arrangement of illustrations, to guide them in the preparation of the manuscript. The following conditions must be observed: Five copies of the manuscript, typewritten in English, should be submitted to the executive office, American College of Chest Physicans, 112 East Chestnut Street, Chicago 11, Illinois, not later than April 1, 1952. The only means of identification of the author or authors shall be a motto or other device on the title page, and a sealed envelope bearing the same motto on the outside, enclosing the name of the author or authors.

Welfare Department Statistics.—The resident population of all mental hospitals, June 30, 1951, was 46,127. During the period May 1, 1951 through June 30, 1951 there were 2,344 admissions as follows: 1,216 mentally ill, 303 in need of mental treatment, 149 mentally defective and 676 voluntary commitments. There were, in addition 270 emergency admissions. The book population of these mental hospitals, June 30, 1951, was 51,188. This includes not only those present, but also all those in out-patient convalescent care.

There were 41 severe injuries during the months of May and June, and 58 new tubercular cases were diagnosed. During these two months there were 5 deaths from serious injuries, 18 from communicable diseases, and 30 from tuberculosis. There were 53 coroner cases and 134 autopsies.

The Veterans' Rehabilitation Center in Chicago and the veterans clinics in Champaign, Peoria, and Rockford received 151 new cases during the months of May and June. During these two months there were 2,494 visits to the clinic in Chicago, 264 in Champaign, 76 in Poria and 44 in Rockford. Since opening these clinics, 7,249 veterans have received treatment in Chicago, 306 in Champaign, 121 in Peoria, and 120 in Rockford.

On June 30, 1951 there were 3,694 veterans present in all state institutions. During the months of May and June, 566 veterans were admitted to these institutions.

The Division of Community Clinics reported 444 new cases during the months of May and June.

There were 2,609 patients interviewed in outpatient psychiatric clinics during the months of May and June, and 4,937 visits were made to these clinics.

State Training Schools for Boys and Girls, and Reformatories for Women and Boys reported 940 juvenile delinquents, felons, and misdemeanants, present June 30, 1951. One-hundred-sixty-nine were received from courts during May and June, and 109 were discharged during these two months.

The pupils at Schools for Deaf and Blind were home for summer vacation June 30, 1951. There were 51 children present at Children's Hospital School and 310 at Soldiers' and Sailors' Children's School at end of June.

The Institute for Juvenile Research interviewed 289 new cases during the months of May and June. There were 561 tests and interviews with children and 511 with parents.

Clinical and diagnostic services for Eye and Ear Infirmary reported 29,402 treatments during the months of May and June, while the clinics for Trachoma Control and Prevention of Blindness reported 2,061 treatments during these months.

Meeting of General Practice.—The Illinois Academy of General Practice will hold its fourth annual convention, October 14-16, 1951, at the Sheraton Hotel, in Chicago. Dr. H. Marchmont-Robinson, president of the Illinois Academy of General Practice; and Colonel James C. Crockett, will deliver the welcome address and introduction, respectively. Speakers participating in the assembly will be Dr. Earl H. Blair, "Duties of Physicians in Atomic Disaster"; Howard Shaughnessy, Ph.D., "Prevention and Control of Infectious Diseases During Atomic and Biological Warfare"; Dr. Lloyd Gittelson, "Disaster Anesthesia"; Dr. J. Garrott Allen, "Treatment of Radiation Sickness"; Dr. Harry A. Oberhelman, "Treatment of Blast Injuries"; Brigadier General Elbert De Coursey, "Atomic Bomb Effects: Teaching Aids from Armed Forces Institute of Pathology"; Dr. Henrietta Herbolsheimer, "Medical Organization for Civil Defense"; Senator Everett McKinley Dirksen, banquet speaker; Dr. A. R. Colwell, "Diagnosis and Treatment of Diabetic Acidosis"; Dr. Herbert Rattner, "Common Skin Disorders and Their Treatment"; Dr. A. V. Partipilo, "Intestinal Obstruction"; Dr. Andrew C. Ivy, "Differential Therapeutic Diagnosis of Jaundice"; Dr. H. Close Hesseltine, "Prolonged Labor and Its Management"; Dr. H. C. Voris, "Emergency Treatment of Head Injuries"; Dr. W. C. Alvarez, "Why Are Some People So Nervous"; Dr. Karl A. Meyer, "Lesions of the Colon"; and Dr. Louis N. Katz, "Some Common E.K.G. Patterns Encountered in General Practice."

DEATHS

Robert G. Bell, Ottawa, who graduated at Rush Medical College in 1920, died July 28, aged 65. He was medical director of the former Ottawa Tuberculosis Sanitarium for many years.

Kenneth Adams Bibby, Waukegan, who graduated at Queen's University Faculty of Medicine, Kingston, Ont., Canada, in 1932, died March 22, aged 44, of pancreatic calculi.

Roy S. Bothwell, Batavia, who graduated at The Hahnemann Medical College and Hospital in 1890 and Rush Medical College in 1891, died July 14, aged 60.

He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

SANFORD R. CATLIN, Rockford, who graduated at Harvard Medical School in 1897, died, July 14, aged 80. He had practiced medicine 54 years and was a member of the Illinois State Medical Society "Fifty Year Club."

WILLIAM W. COLEMAN, retired, Lincoln, who graduated at Missouri Medical College, St. Loius, in 1899, died June 28, aged 76. He practiced medicine in Lincoln from June, 1904, until his retirement in 1949.

WILLIAM E. FRANKE, retired, Newton, who graduated at St. Louis College of Physicians and Surgeons in 1892, died August 4, aged 81. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

HARRY C. GEBHART, Champaign, who graduated at Rush Medical College in 1916, died July 15, aged 64. He began his medical practice in Champaign-Urbana in 1926.

HOMER JAMES GORDON, Chicago, who graduated at Chicago Medical School in 1921, died March 31, aged 53, of carcinoma.

JOHN JACOB HESSER, Chicago, who graduated at Magyar Kiralyi Pazmany Petrus Tudomanyegyetem Orvosi Fakultasa, Budapest, Hungary, in 1909, died March 30, aged 64.

EDWARD J. HORICK, Elmhurst, who graduated at Rush Medical College in 1924, died July 26, aged 57. He was on the staff of the DuPage Memorial Hospital and had practiced medicine in Elmhurst since 1930.

GEORGE A. LEACH, Morris, who graduated at The Hahnemann Medical College and Hospital in 1901, died July 21, aged 88. He had served as city health physician at Morris.

WALTER C. REINEKING, Jacksonville, who graduated at Wisconsin College of Physicians and Surgeons in 1907, died July 11, as the result of an automobile accident. He was 70 years of age. He had served on the staff of Oak Lawn Sanatorium, Jacksonville.

ARTHUR WILLIAM ROBERSON, Chicago, who graduated at Meharry Medical College, Nashville, Tenn., in 1919, died April 25, aged 56, of concussion of the brain resulting from a fall.

HENRY O. ROGIER, retired, Mason City, who graduated at St. Louis University School of Medicine in 1906, died July 17, aged 70.

CHARLES A. RUNYON, Elveston, who graduated at College of Physicians and Surgeons, Keokuk, Ia., in 1884, died July 15, aged 90. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

ARTHUR L. SHREFFLER, Joliet, who graduated at Northwestern University Medical School in 1911, died August 10, aged 66. He was on the staff of Silver Cross and St. Joseph Hospitals in Joliet, and was a past president of the Will-Grundy County Medical Society.

"FOR THE COMMON GOOD"

Health Talk on TV.—Since the last issue of the ILLINOIS MEDICAL JOURNAL, the following telecasts have been presented by the Educational Committee over WGN-TV, Channel 9, on Tuesday evenings at 7:30 p.m.

William B. Raycraft, July 31, The Rheumatic Heart.

Louis R. Limarzi and Paul L. Bedinger, August 7, The Story of Blood. The Precision Scientific Company provided equipment for this telecast.

Albert H. Unger and Mr. Oren C. Durham, August 14, Hay Fever.

Gordon H. Rovelstad, D.D.S. and Samuel Hoffman, August 21, Preventing Tooth Decay.

Your Doctor Speaks Over WFJL, Thursday evenings at 7:30 p.m., carried the following transcribed broadcasts under the auspices of the Educational Committee since the last issue of the JOURNAL:

George W. Holmes, August 2, Surgery in Tuberculosis.

Irwin Dritz, August 9, Modern Anesthesia.

Earle I. Greene, August 16, That Lump in Your Neck.

Here Is Your Doctor Over WCFL, Saturday mornings at 11 a.m., weekly transcribed series is currently off the air but will be resumed some time in the fall.

Lectures Arranged Through the Educational Committee:

William W. Bolton, September 16, Young Married Couples Sunday Evening Club, Superstitions About Health.

Edward Webb, Chicago, September 26, Mothers' Study Club, in Elgin, on Prevention of Eye Problems in Young Children.

Lectures Arranged Through the Scientific Service Committee:

William K. Riker, Chicago, September 11, Bureau County Medical Society, in Spring Valley, on Certain Aspects of Pediatric Surgery, illustrated.

Walter Reich, Chicago, October 16, Iroquois County Medical Society, Watseka, Office Gynecology, illustrated.

Elizabeth A. McGrew, Chicago, October 26, McDonough County Medical Society, Macomb, Detection of Genital Tract Cancer in Asymptomatic Women by the Cytologic Method, illustrated.



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Keefer, Chester S.: Am. J. Med. 7:216



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Keefer, Chester S.: Ann. Int. Med. 33:582



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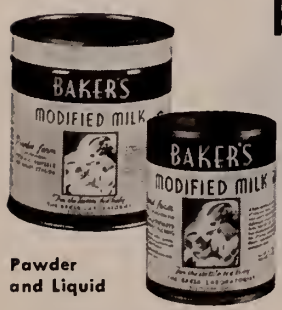
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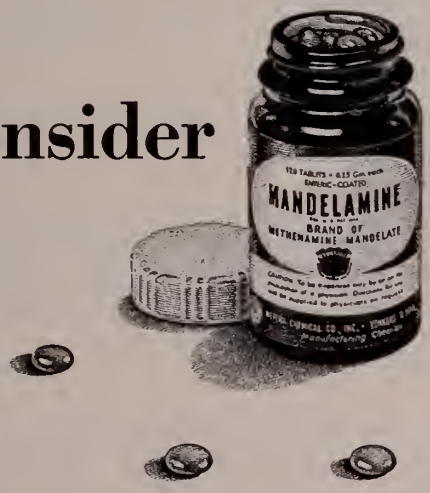
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PHYSICAL MEDICINE ABSTRACTS



NON-ARTICULAR RHEUMATISM

Richard Harold Freyberg, M. D. In BULLETIN OF NEW YORK ACADEMY OF MEDICINE, 27:-4:245, April 1951.

The commonest form of non-articular rheumatism affects the fibrous connective tissue and consequently has been called "fibrositis." Its treatment is supportive and symptomatic. Usually it is helpful for the patient to avoid strenuous physical activity and to procure additional rest during the daytime, but it is a mistake to curtail ordinary activity and recreation that is not fatigue-producing. Mild exercise especially after application of heat usually relieves the stiffness and aching; however, prolonged physical activity commonly increases the discomfort. Heat relieves; massage gradually made rather "firm" usually is helpful. Hot packs are helpful for severe localized pain and warm baths are the best means of heating the whole body.

Inflammation of a bursa is a common form of localized fibrositis. Since bursae exist about all large joints and some small ones, bursitis may occur in many locations. Treatment should be directed to relieve pain and to maintain function; reassurance should be given that the disorder is localized and comparatively mild. Radiant heat or diathermy may relieve, but sometimes aggravate the pain; then cold applications usually relieve. Rest of the shoulder is advisable during the acute phase; graded exercises to restore motion should be instituted as soon as pain lessens. Procaine block of the superior cervical ganglion or brachial plexus will give temporary relief and allow exercise of the shoulder to avoid stiffness.

The shoulder-hand syndrome is an interesting and incompletely understood form of non-articular rheumatism which may follow myocardial infarction or other painful intrathoracic lesions, cerebral vascular accidents, irritative lesions in the neck or upper extremity, and sometimes exists without recognizable cause. It is characterized by pain in the shoulder or hand, commonly in both parts; it may be unilateral or bilateral. Shoulder motion becomes limited and the affected hand becomes edematous and painful so that it is held stiff. After several weeks, atrophy occurs in the shoulder and hand and adhesions or contractures limit motion in the affected parts. Treatment with the usual physical measures and analgesics commonly fails. Procaine block of the brachial plexus or superior cervical ganglion usually is an effective means of temporarily allaying pain, which should be accomplished early in the illness, so that functional exercises can be performed to prevent stiffness. If stiffness of shoulder and/or hand results, rehabilitation depends upon persistent physical and occupational therapy.

A STUDY OF THE ADJUSTMENT OF 500 PERSONS OVER SIXTEEN YEARS OF AGE WITH DISABILITIES RESULTING FROM POLIOMYELITIS

George G. Deaver, M. D. In NEW YORK MEDICINE, 7:7:16, April 5, 1951.

There has been much speculation about the proportion of persons with residual disabilities from poliomyelitis, who having received extensive care and treatment through childhood, nevertheless by the time they approach adult life, have not achieved their maximum capacity to perform the physical activities inherent in

(*Continued on page* 54)

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daily living and working. In order to obtain authentic information on this subject this study was undertaken, and the following conclusions were reached:

(1) When patients with poliomyelitis are left with a residual disability, it is to be expected that some will have no handicap in performing the physical activities of daily living; others will be handicapped but able to meet these demands adequately; and others will have inadequate compensations. Inadequate follow-up of patients results in three times as many persons with inadequate compensation.

If the disabled are taught to perform the activities of daily living, it is probable that only three per cent could not be trained and employed in positions suited to their abilities and disabilities.

(2) The large majority have the mental and physical capacity to lead a normal life and achieve a satisfactory social and emotional adjustment.

(3) Psychological factors are no less important than physical factors in the adjustment of the disabled and should receive scientific study and treatment to the same extent as physical factors.

(4) Social service, with many exceptions in individual cases, was on the whole extremely inadequate for the group studied.

(5) The educational attainment of these disabled persons seemed to be equal to that of the general population of the city.

(6) The rate of employment for the group studied was 15 per cent lower than for the general population of New York City.

(7) Deprivation in social activities seems to be an even more important factor in maladjustment than lack of vocational opportunities.

(8) There is little difference between the sexes in regard to extent of disability, education and general adjustment, but women are worse off than men in regard to employability, economic status, social life, and attitude toward the disability.

(9) Among the subjects that should receive further investigation, as indicated by the data of this study are:

a. The use that is made of existing opportunities for vocational guidance and training.

b. The role of social service in rehabilitation.

c. The importance of emotional factors in adjustment, with particular reference to rehabilitation, education and employment.

d. The effect of parental over-protection on social and emotional adjustment.

FRACTURES ABOUT THE ANKLE

Rex L. Diveley, M. D., Kansas City. In THE JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION, 48:6:437, June 1951.

Diveley's routine in fractures about the ankle is to reduce them at the earliest possible moment and immobilize in a plaster cast. Early weight-bearing is highly satisfactory provided firm immobilization of the fragments can be maintained. At the end of two weeks, a heel piece or walking iron may be incorporated in the cast, and weight bearing insisted upon.

The after-treatment or period of rehabilitation is most important in ankle fractures. At the end of from six to eight weeks, depending upon the severity of the fracture, the cast is bivalved and physical therapy in the form of massage, passive and active exercises with whirlpool is given. In ten days or two weeks, it the x-ray examination shows an adequate union of the fragments, the cast may be discarded and the foot fitted in a strong supporting shoe. Any existing foot imbalance must be corrected by supports and shoe alterations or both.

PARKINSONISM AND RHEUMATOID ARTHRITIS

Ralph O. Wallerstein, M. D., Boston, Mass. In ANNALS OF INTERNAL MEDICINE, 34:4: 899, April 1951.

Eighty years ago Charcot first called attention to the possible relationship between Parkinsonism and rheumatoid arthritis. Since then several investigators have pointed out similarities between the two diseases.

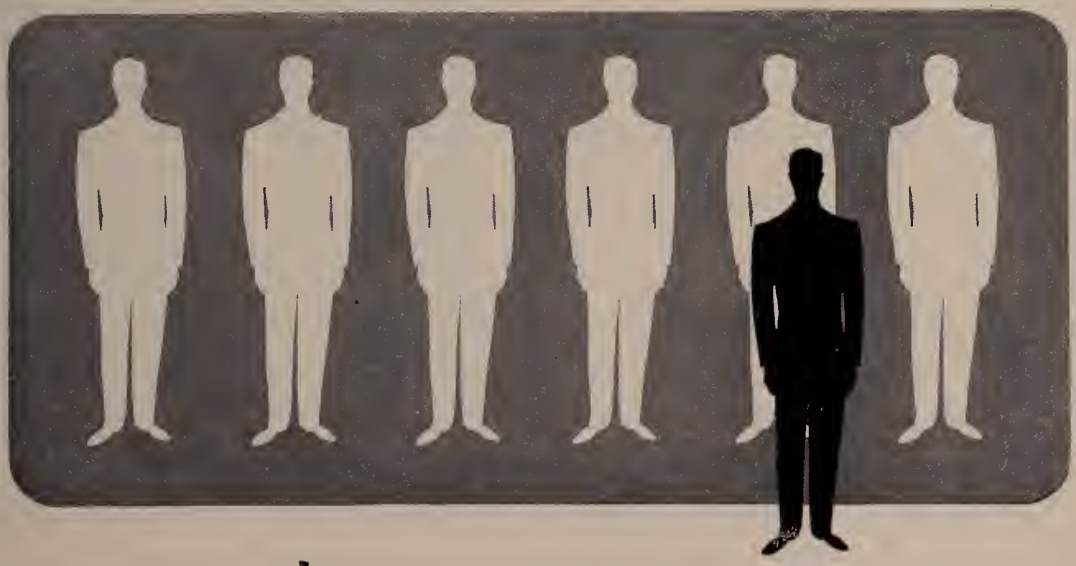
In an effort to evaluate critically the relationship between the two diseases, 19 patients with frank clinical paralysis agitans, and 28 patients with far advanced, chronic atrophic arthritis were examined.

In most patients with Parkinsonism the onset of illness had been very gradual; weakness and tremor had been the first symptoms. In conducting the examinations, attention was focused primarily on the joints. In the majority of the patients, the appearance of the hands bore a marked resemblance to the hands found in chronic rheumatoid arthritis. There was ulnar deviation of the wrists and fingers, flexion at the metacarpophalangeal joints, extension at the phalangeal joints and adduction of the fingers and thumb; in other words, all muscles innervated by the ulnar nerve seemed overactive. Poverty of motion of trunk and face, with attitude of flexion at elbows and knees, enhanced this resemblance. But whereas in atrophic arthritis there is a true loss of mobility, affecting passive as well as active motion and usually ankylosis and deformity, full range of motion could be obtained in the joints of patients with Parkinsonism after overcoming the muscular rigidity by passively flexing and stretching all the large and small joints of the extremities.

The patients suffering from rheumatoid arthritis had a definite story of onset with fever and joint pain. In all patients the disease had progressed to complete crippling, with joint destruction and ankylosis.

(*Continued on page* 56)

In one out of six patients



no symptoms

but *all* 34 patients in this study carried Endamoeba histolytica[1] in their stools! Five were classified as asymptomatic and 18 were "persons with such poorly defined symptoms that they would not normally seek medical assistance...," but a stool examination proved that all had amebic dysentery.

In these instances, a course of treatment with Milibis-Aralen was completely successful. Milibis — bismuth glycolylarsanilate — a new intestinal amebacide, is one of the most powerful of the drugs commonly used against Endamoeba histolytica.[2] Yet its toxicity is so low that side effects are virtually unobserved.

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1. Towse, E. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.
2. Berberian, D. A., Dennis, E. W., and Pipkin, C. A.: *Am. Jour. Trop. Med.*, 30:613, Sept., 1950.

588M

Only one patient appeared to have both diseases. In view of the number of cases of Parkinsonism (19) and rheumatoid arthritis (28) among a group of 500 patients, this coincidence cannot be considered significant.

There appears to be no increased incidence of rheumatoid arthritis among patients suffering from Parkinsonism.

VISUAL AND MOTOR CHANGES IN PATIENTS WITH MULTIPLE SCLEROSIS: A RESULT OF INDUCED CHANGES IN ENVIRONMENTAL TEMPERATURE

Thomas C. Guthrie, M. D., New York, New York. In ARCHIVES OF NEUROLOGY AND PSYCHIATRY, 65:4:437, April 1951.

Climate and temperature have been recognized as affecting the incidence of multiple sclerosis. Although sex and race appear not to be important factors in its occurrence, its geographical distribution seems to vary significantly with the distance of an area from the equator. According to one study of the mortality statistics in 14 countries, there is "an inverse and rather striking relationship between reported mortality due to multiple sclerosis and mean annual temperature. The colder the climate, the higher the crude death rates for multiple sclerosis." A definite statistical relationship of multiple sclerosis to seasonal variations in temperature does not seem to exist.

In the past, in an attempt by physicians to discover effective therapeutic approaches to multiple sclerosis, patients have been subjected to various forms of heating. On the rationale that the disease may be caused by a virus and that a heat-sensitive organism may be found in the spinal fluid, 12 patients were subjected to immersion in a hot bath at 110 F. and 10 minutes. After 115 baths given to the 12 patients, the condition of four showed improvement; that of six showed no change, and that of two became worse. In a general discussion of therapy with hot baths, to patients with multiple sclerosis, the observation was made that "muscle weakness ordinarily was not favorably influenced."

Several attempts have been made to treat multiple sclerosis with electropyrexia. With local diathermy, given over the spinal cord, to 13 patients, 10 showed improvement; one relapsed and was then cured; one became worse, and one had questionable results, but the criteria for improvement are vague, and no control series is reported. In general reference

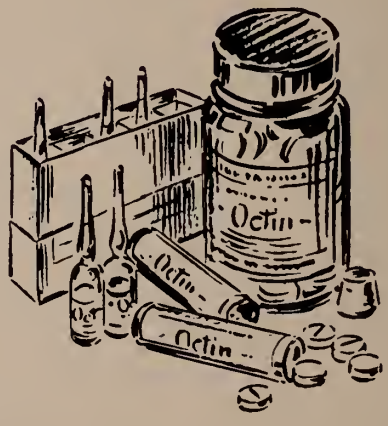
(*Continued on page* 58)

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1... relaxation of smooth muscle spasm especially of the genito-urinary and gastro-intestinal tracts
2... in migraine and related headaches.

DOSE: Oral, 1 or 2 Octin tablets, 1 additional tablet in three to four hours.

Intramuscular injection, ½ to 1 cc. Give test dose to determine absence of sensitivity and excessive hypertensive reaction.



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The average human body has a surface skin area of 18 to 20 square feet—and every inch is at all times susceptible to one skin disorder or another.

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	CASES	CLEARED OR MARKED IMPROVEMENT	MODERATE IMPROVEMENT	SLIGHT OR NO IMPROVEMENT
CHRONIC RECURRENT CONTACT DERMATITIS	11	9	1	1
PSORIASIS	11	2	4	5
NEURODERMATITIS	5	3	2	–
ATOPIC ECZEMA	8	6	1	1
SEBORRHEIC DERMATITIS	6	5	1	–
VARICOSE ECZEMA	4	1	1	2
ALLERGIC DERMATITIS	3	–	2	1
LICHEN PLANUS	3	2	1	–
TOTAL	51	28	13	10
%		54.9	25.5	19.6

For prescriptions—all pharmacies stock 2¼-oz. & 8-oz. jars; for dispensing purposes, 1-lb. & 6-lb. jars available thru your surgical supply dealer.

**Lowenfish, F.P., N.Y. State J. Med., 50:922 (Apr. 1) 1950.*

THE TARBONIS COMPANY Dept. ILL
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Please send literature and clinical sample of TARBONIS

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to electropyrexia, the comment has been made that fever may bring out latent neurological abnormalities.

In general, while hot baths, diathermy, fever cabinets and pyrexia induced with foreign protein have been tried several times in the treatment of multiple sclerosis, inconclusive results have gradually led to their disrepute as effective agents.

Of the changes that seem to appear during heating, the generalized weakness, arm weakness, leg weakness and dysarthria have, in general but not always, been present in the patients with multiple sclerosis before heating. The effect of the hot baths seems mainly to have been one of rendering these dysfunctions more evident.

AN ASSESSMENT OF THERAPY IN PARKINSON'S DISEASE

Robert S. Schwab, M. D., Boston, and John S. Prichard, M. B., M.R.C.P., London, England. In ARCHIVES OF NEUROLOGY AND PSYCHIATRY, 65:4:489, April 1951.

Since 1817, when James Parkinson recognized the entity of paralysis agitans among the heterogeneous collection of tremors and paralyses, the most persistent attempts have been made to treat this disease. Charcot thought some of his patients were benefited by riding on horseback. Consequently, he had constructed a *fauteil trepidant,* on which he made his patients sit and shake for stated periods. A pupil of his, Gloreux, was so impressed with this idea that he prescribed for his patients a two hour ride each day on as bumpy a conveyance as was possible.

During the past five years patients with paralysis agitans were given four types of treatment, as well as combinations of them: physical therapy, psychotherapy, surgical treatment, and drug therapy.

The physical therapy consisted of either the routine therapy with massage and passive motion, or intensive progressive resistance exercises of the involved muscles under the direction of Dr. T. L. DeLorme. As concerns the effect of physical therapy of the routine type, namely, referral of the patient to the physical therapy department two or three times a week for massage and passive motion, or having a masseur come to the patient's home two or three times a week for the same treatment, Schwab and Prichard formed the following impression: During the actual massage and passive exercises the patient almost always felt better.

(*Continued on page 60*)

for the **ULCER PATIENT...**

DOUBLE COMFORT



PROMPT, PROLONGED PAIN RELIEF **WITHOUT ACID REBOUND**

CHART LEGEND
The tablet material (2 gm. equivalent to 30.8 grains Doraxamin) was added to 150 cc. artificial gastric juice and stirred at 37 degrees C. Every 10 minutes there was removed 20 cc. of the mixture which was replaced by 20 cc. of fresh artificial gastric juice. At regular intervals the pH of the mixture was determined with a Beckman pH meter.

FOR THE TREATMENT of peptic ulcer and hyperacidity, the market has long afforded neutralizing agents which are satisfactory to a degree. Frequently, however, a dosage sufficient for prompt, lasting pain relief brings in its wake a discouraging acid rebound.

Doraxamin brand of dihydroxy aluminum aminoacetate rules out this reaction. Because it is a chemical combination of aluminum with glycine, one of the amino acids, it provides both rapid acid neutralization by the amino acid and a secondary prolonged buffering of acid by the decomposition of the aluminum salt of the glycine.

Doraxamin raises the pH of artificial gastric juice to approximately 3.9 in ten minutes, and maintains a pH of above 3.0 for two hours. Repeated tests have shown conclusively that, even when Doraxamin is given in excess, the pH never reaches a maximum of more than 4.5. There is, therefore, no danger of alkalosis and no acid rebound.

References:

1 Krantz, Kibler and Bell: "The Neutralization of Gastric Acidity with Basic Aluminum Aminoacetate," J. Pharmacol. and Exper. Therap., 82:247 (1944).

2 Paul, W. D., and Rhomberg, C.: "Medical Management of Uncomplicated Peptic Ulcer," J. Iowa M. Soc. 35:167-85 (1945).

3 Holbert, J. M., Noble, Nancy, and Grote, I. W.: J.A.Ph.A., Scientific Edition, 36:149 (1947).

4 Holbert, J. M., Noble, Nancy, and Grote, I.W.: J.A.Ph.A., Scientific Edition, 37:292-294 (1948).

TABLETS
Doraxamin
BRAND OF DIHYDROXY ALUMINUM AMINOACETATE

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The Importance of

PREVENTING BORDERLINE NUTRITIONAL STATES IN CHILDREN

IN recent years increasing interest has been focused on the relationship between nutrition and the physical, mental and emotional development of children. It is now well recognized that listlessness and apathy in the child frequently may be nothing other than manifestations of a borderline nutritional state resulting from faulty food selection and inadequate consumption. Moreover, such sequelae of faulty nutrition often respond dramatically to improved food habits.*

For preventing borderline nutritional states in children due to food whims, poor choice of foods, or lack of interest in eating, Ovaltine in milk enjoys long-established usefulness. Its rich content of biologically complete protein, vitamins and minerals can supplement even grossly deficient diets to optimal nutrition. The delicious flavor of Ovaltine invites its acceptance and lends interest to eating when the appetite lags. Children particularly like Chocolate Flavored Ovaltine.

Three servings of Ovaltine in milk furnish the supplementary amounts of nutrients shown in the appended table.

*Baumgartner, L.: Wider Horizons for Children; The Mid-century White House Conference and Children's Nutrition, J. Am. Dietet. A. 27:281 (Apr.) 1951.

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Three servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk, provide:*

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FAT	32 Gm.	VITAMIN B_1	1.16 mg.
CARBOHYDRATE	65 Gm.	RIBOFLAVIN	2.0 mg.
CALCIUM	1.12 Gm.	NIACIN	6.8 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN C	30.0 mg.
IRON	12 mg.	VITAMIN D	417 I.U.
COPPER	0.5 mg.	CALORIES	676

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

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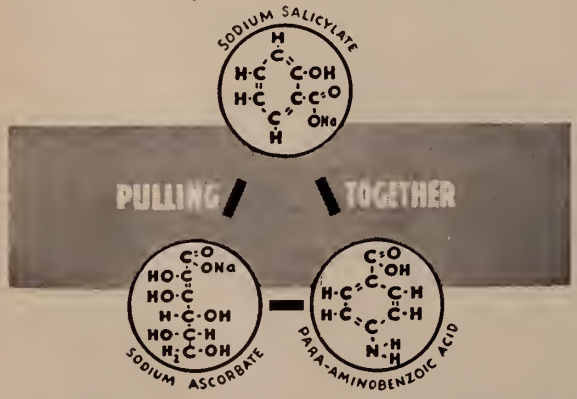
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Physical Medicine (Continued)

He was more relaxed and comfortable. As soon as the patient left the physical therapy department, his symptoms returned, and the benefit of the treatment lasted only an hour or two at the very most. There was no evidence in this type of physical therapy of any true benefit, change in symptoms, improvement in signs or alteration in the progress or state of the disease.

The special approach through progressive resistance exercises is a separate project, in which a specific weakness or stiffness in one muscle group, for example, in left leg, or even both legs, rather than a generalized involvement, is the chief disability. These patients are seen in consultation with Dr. T. L. DeLorme and are taken into this project only if they are willing to come in for two to three hours' treatment, four times a week, for two to three months. The other forms of therapy, usually medication, which the patients have been receiving are kept exactly the same throughout this period of observation. Careful assessment is made each week as to changes in signs and in the patient's ability to perform his usual tasks at home and at work. At the end of the project the treatment is stopped for a period of at least a month to see whether any improvement attained has regressed.

In a preliminary group of five patients receiving this type of treatment, three have greatly improved in their strength and muscle function and in the ability to use these muscles in normal activities, such as walking and climbing stairs. There has also been a favorable improvement in mood. However, there is no alteration in the objective signs, such as tremor or rigidity or loss of associated movements. One patient in this group continued for six weeks and then reverted suddenly to the previous level after he had been badly shaken up in an automobile accident. This stress was sufficient to make the period of treatment following the accident (one month) ineffective. The fifth patient showed no improvement in any form, and the treatment was discontinued at the end of a month.

CLINICAL NOTES ON AN EPIDEMIC OF POLIOMYELITIS

Ned M. Shutkin, M. D., Gastonia, N. C. In ANNALS OF INTERNAL MEDICINE, 34:3:655, March 1951.

Those cases with only spinal paralysis were put to bed, kept comfortable with analgesics and barbiturates if necessary, and given physical therapy as early as possible but not until it could be done without adding to the patients' discomfort. The controversies raging among the physical therapists as to the advisability of immediate or deferred

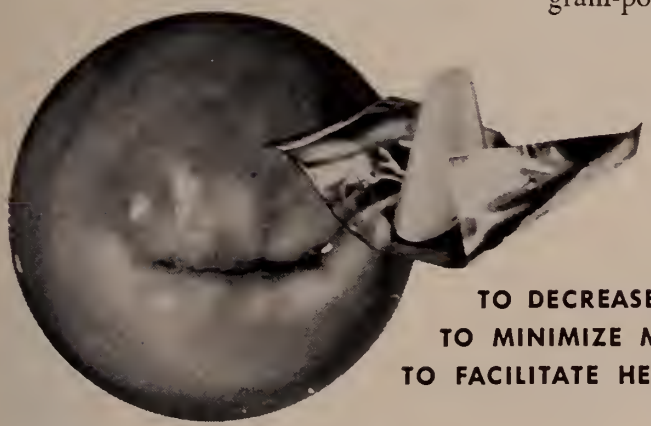
(*Continued on page* 62)

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Postoperatively, following hysterectomy or conization of the cervix, their use facilitates primary healing by controlling the surface infection. Likewise, they can decrease greatly the slough, drainage and malodor.

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These suppositories are indicated for bacterial cervicitis and vaginitis, pre- and postoperatively in cervical and vaginal surgery.

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Physical Medicine (Continued)

stretching, gentle or forceful stretching, or the use of hot packs are so many "storms in teacups." Approaching the subject on the basis of rational physiology, it should be obvious that stretching a tight muscle, be it early or late, could not possibly alter a disease process located in the spinal cord. Furthermore, the precise reason for stretching must be appreciated. One must differentiate between the contraction of the presumably spastic muscle in the acute phase and the contracture of the noncontractile connective tissue in and about the muscle following the acute phase. It is no more reasonable to expect stretching of the contracted muscle in the acute phase to produce relaxation of the muscle than it would be reasonable to expect relaxation of a spastic muscle from stretching in a case of cerebral palsy. Hence it becomes obvious that the only valid reason for stretching a tight muscle in the acute phase is to obviate subsequent contracture of the noncontractile connective tissue elements in or about that muscle. It was our experience that no contractures developed from gentle, unhurried muscle stretching done at a time and at a pace that did not increase the patient's discomfort.

Hot packs were used only sparingly, for several reasons. In the first place, a hot pack program carried out according to protocol would have completely usurped the time and efforts of the insufficient personnel, who were taxed to the utmost taking care of the direly ill bulbar and respiratory cases. Secondly, the great majority of uncomfortable patients obtained prompt and adequate relief from judicious doses of aspirin and phenobarbital. Thirdly, it was deemed unwise to subject our acutely ill patients, so many of them under three years of age, to the additional exhaustion, dehydration and electrolyte depletion attendant upon a full-scale hot pack program, particularly during the hot summer months. Most important of all, however, is the fact that hot packs were not necessary. As previously stated, physical therapy prevented contractures, with only aspirin and phenobarbital to allay the discomfort. In a few instances where muscle soreness and tightness were extreme, even to the extent of producing opisthotonus, hot packs were employed and, true enough, were effective in relieving the tightness, but only during the period they were applied. Following removal of the packs, the tightness promptly returned, and to a degree comparable to that present prior to application of the pack; nor was there

(*Continued on page* 64)

PROMPT PAIN RELIEF...
RAPID, PROLONGED
ANTACID ACTION...
HIGH ACID-BUFFER
ACTION...
LOW ALUMINUM
CONTENT...
NO ACID REBOUND
...PLEASANT
TASTE... NO
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Thiamine Hydrochloride	3 mg.
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The practical value of an antispasmodic depends upon the degree of a desirable spasmolytic effect, convenience of administration and patient acceptance.

Degree of spasmolytic effect of belladonna alkaloids rests upon the intensity of parasympathetic inhibition. Pure levorotatory belladonna alkaloids (Bellafoline) are more potent and selective than belladonna alkaloid mixtures in producing this spasmolytic effect, at the same time minimizing the undesirable cerebrospinal effects.

Studies by *Kramer and Ingelfinger,* (M. Clin. North Amer., Boston No.: 1227, (1948) demonstrate the highly efficient action of Bellafoline. By balloon-kymograph studies on the human intestine they found that most commonly used antispasmodics are less effective than atropine (standard dose: 1/100 gr.). Bellafoline was the outstanding exception. It surpassed atropine in both degree and duration of action.

The antispasmodic effect of Bellafoline is augmented by a small dose of phenobarbital thereby reducing underlying excitability and tension.

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Thus Elixir Belladenal fulfills the requirements for practicality by reason of: high efficacy, patient acceptance, convenience of dosage regulation. It is especially serviceable in pediatrics and in those adults where the use of tablets is impractical. The teaspoonful dose contains Bellafoline (levorotatory alkaloids of belladonna leaf) 0.0625 mg. and Phenobarbital 12.5 mg. The indications are those of Belladenal Tablets, e.g. Peptic ulcer, Pseudo-ulcer, Spastic colon, other hypermotility-hypersecretion states of the gastrointestinal-biliary tracts and genito-urinary spasm. Professional Samples and Literature available upon request.

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Physical Medicine (Continued)

any evidence indicating that the use of hot packs shortened the duration of the tightness.

Following subsidence of the acute stage, therapy was directed toward three objectives: prevention of fixed contractures; strengthening, insofar as possible, surviving muscle elements, and coordination of residual and substitute motion. Position of function was maintained, insofar as possible, by means of sand bags, foot boards, shoe bars, pillows, slings and other gadgets designed to fit the individual requirement. This aspect of convalescent care cannot be too strenuously enforced. It is folly to expect a convalescent but otherwise healthy child to remain immobile in any fixed position for days on end. As long as adequate daily physical therapy maintained suppleness in the soft tissues, no deformities occurred. Braces were employed as early as feasible, not so much to obtain immobilization as to allow mobilization. It was felt that active use of weakened muscles while supported in a position of mechanical advantage abetted the strengthening process. Plaster casts were used infrequently, and only in those few cases where deformities occurred or seemed imminent as a result of muscle imbalance that defied the efforts of the physical therapist. Although not so deplorable as soft tissue contracture in the position of deformity, contracture in the position of function, plus the disuse atrophy of surviving muscle elements from prolonged plaster immobilization, certainly is not much more desirable.

NYLON ARTHROPLASTY IN RHEUMATOID AND OSTEO-ARTHRITIS

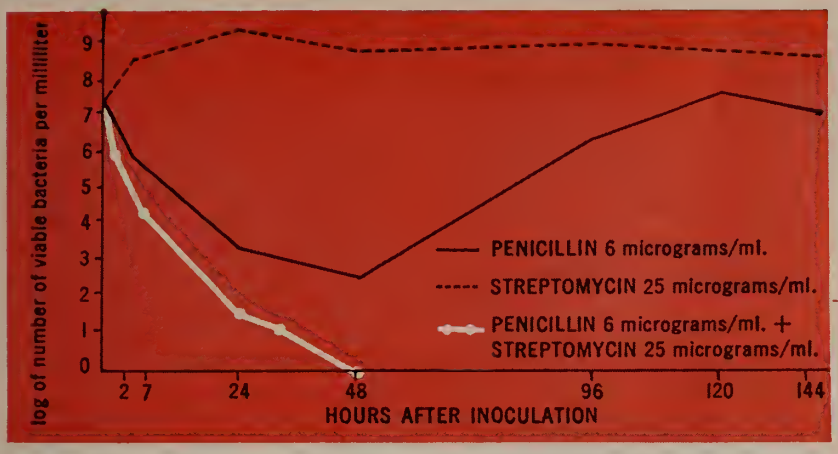
John G. Kuhns and Theodore A. Potter, Boston, Mass. In ANNALS OF THE RHEUMATIC DISEASES, 10:1:22, March 1951.

After operation to form a new knee joint, the leg usually is kept elevated upon pillows for 48 hours. Transfusions of one to two pints of blood usually are given as well as penicillin as prophylactic measures. Muscle-setting exercises are begun before the end of the first week after oepration. Active exercises are begun after one week. Movement against gravity is begun as soon as the wound is healed. Weight-bearing with crutches and a plaster cylinder are begun in three weeks unless there is much bony atrophy. Resistance exercises (De Lorme and Watkins, 1948) are given to regain normal strength in the extensor muscles. Six months usually are required to regain normal strength and good function.

Arthroplasty of the knee in chronic arthritis is always an operation of election. It does not pro-

(*Continued on page* 66)

"true synergism" in an antibiotic combination



Potentiation of penicillin action by addition of streptomycin: in vitro effect on enterococci

Adapted from Jawetz, E.; Gunnison, J. B., and Coleman, V. R.: Science 111:254 (March 10) 1950.

in vitro: "The combined effect of streptomycin and penicillin on enterococci is evidently more than a summation of the individual drug effects... the increased effect... must be a true synergism of the two drugs."[1]

in therapy: "From the results obtained [in 8 cases of subacute enterococcic endocarditis] there can be little doubt that the concurrent administration of penicillin and streptomycin provides highly effective therapy. Moreover the results are obtained without... using massive doses of penicillin..."[2]



In each single dose vial

Combiotic* P-S

Penicillin and dihydroStreptomycin

provides for intramuscular injection, the synergistic action of:

crystalline procaine penicillin G 300,000 units
buffered crystalline sodium penicillin G . . . 100,000 units
dihydrostreptomycin (as the sulfate) 1 Gm.
for one 3 cc. aqueous injection, easily prepared by the addition of sterile aqueous diluent.

Combiotic P-S is supplied in a special silicone treated "drain-clear" vial.

1. Jawetz, E.; Gunnison, J. B., and Coleman, V. R.: Science *111*:254 (March 10) 1950.
2. Tompsett, R., and McDermott, W.: Am. J. Med. 7:371 (Sept.) 1949.

*Trademark

ANTIBIOTIC DIVISION Pfizer CHAS. PFIZER & CO., INC., *Brooklyn 6, N. Y.*

Physical Medicine (Continued)

duce a normal knee joint but usually results in a useful joint with a fairly wide range of painless motion. In operations of this nature the postoperative period is most important, since motion depends upon the avoidence of complications and the early and persistent activity of the patient. The patient must begin motion or muscle-setting procedures within a few days, and active and resistance exercises of increasing strenuousness must be performed after wound-healing to secure good motion and normal strength. In a few patients normal strength and good function have gradually come after a year and a half, but we do not advocate such slow convalescence; adhesions and muscular stiffness can develop too readily.

The desideratum after arthroplasty of the knee has changed little in the last 50 years; it is a stable, painless knee with about 60° of motion. In a recent review, Speed and Trout (1949) stated that 70° of motion made for the greatest endurance and stability, but many of our patients have over 90° of motion and all of them are stable and painless. The greater range of motion, we believe, has resulted from the vigorous use of the newer physical therapy technics, particularly resistance exercises.

RUPTURES OF THE ROTATOR CUFF

H. F. Moseley, Montreal, Canada. Hunterian Professor, Royal College of Surgeons of England; Assistant Professor of Surgery, McGill University; Associate Surgeon, Royal Victoria Hospital, Montreal. In THE BRITISH JOURNAL OF SURGERY, 38:151:340, January 1951.

In acute ruptures if the case is seen early and the diagnosis is doubtful, careful observation of the progress of the case under active exercise therapy should be the course to follow. If improvement in range and power rapidly occurs during the following three to six weeks, the surgeon can be content with nonoperative treatment.

In chronic ruptures if there is considerable stiffness of the shoulder, especially when tested in adduction, giving a limitation of external and internal rotation, active exercises under supervision should be arranged for several months before exploration is considered.

In repair of the deltoid it is essential to obtain a perfect replacement and suture of the reflected deltoid. A pressure dressing is applied at operation which is removed the following day. Early ambulatory treatment is routine. Time in hospital has varied, but averages less than one week.

The problem of immobilization in adduction or

(*Continued on page* 68)



NUMOROIDAL SUPPOSITORIES

Soothing the Hemorrhoidal Area... Analgesic, vasoconstrictive medication in contact with the entire hemorrhoidal zone is provided in Numoroidal Suppositories. The special emulsifying base mixes with the secretions to assure coverage of the rectal area.

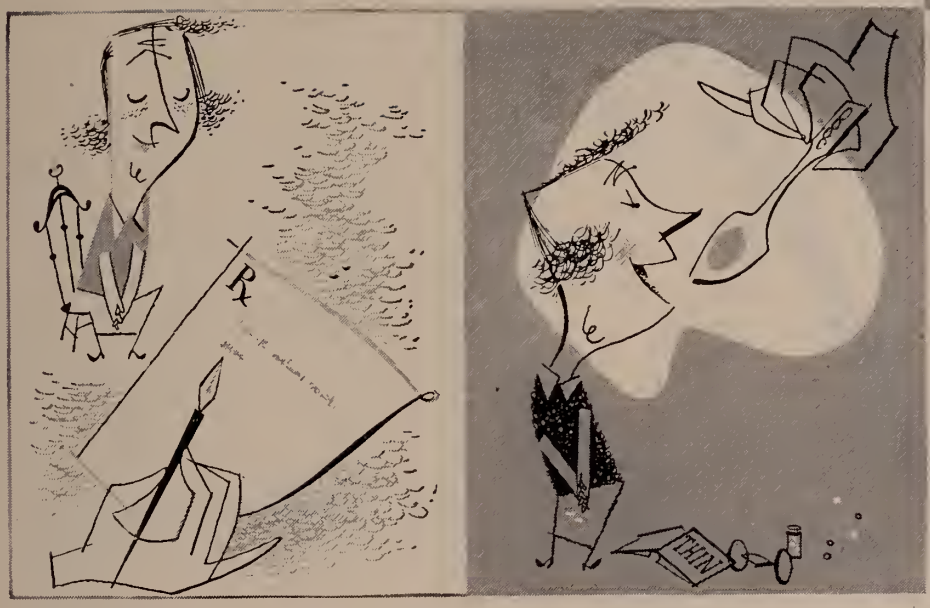
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Physical Medicine (Continued)

abduction has not been resolved. During the winter months in Canada abduction splints and the plaster spica make clinic attendance almost impossible. For this reason these have been employed mostly in repairs of chronic cases when the tension of suture was relieved by the position 90°, 30°, 30° as found at operation. The usual position has been in a sling.

The principle followed in this series is that the surgeon who has carried out the operation must supervise the process of reeducation. Gentle forward and backward movements of the arm, and the complete movements of the elbow, wrist, and hand are encouraged from the beginning. Movements of the shoulder itself are gradually begun after three weeks. All movements are initiated by using the relaxed muscle position. The patient is never permitted to attempt to abduct the arm without assistance for at least six weeks. The weight of the arm would be sufficient to injure the area of repair. Besides the use of the relaxed muscle position, abduction can be initiated by using the method of Colin MacKenzie. The patient rests supine on a couch and the arm is allowed to slide in abduction and adduction on a smooth surface. In this way the weight of the arm and friction are obviated. It usually is necessary to begin these movements in a position in front of the coronal plane.

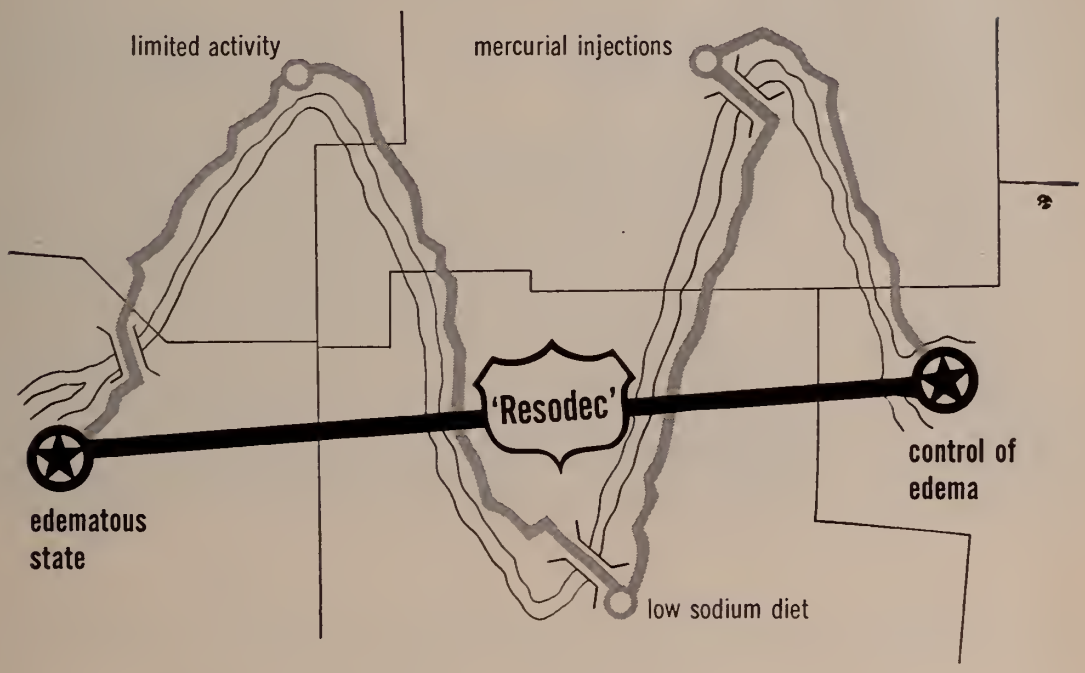
Depending upon the progress, the next step at four to six weeks is graduation to pulley exercises. Movements in forward flexion are encouraged before those in abduction, and the progress in the range of forward and backward flexion is always in advance of the range obtained in abduction. Every attempt is made to teach the patient movements of the humeral joints and to avoid shrugging the shoulder by using the girdle movements which is the natural tendency.

In time the physical therapist can employ increasing resistance to the muscles to augment their power, but this should not be an important part of the treatment until after three months. The range of movements always is first obtained before an effort is made to secure power. Supervision is required for four to six months to secure a good result.

When the patient is treated in the position 90°, 30°, 30°, movements above this plan are encouraged and the patient is taught to keep all the muscles of the limb in activity. This position usually has been maintained for six weeks and the case is readmitted for removal of the splint, as this may be painful and the arm should be gradually adducted while the patient is in bed. The program of reeducation should then follow the pattern outlined above. Sometimes a vascular disturbance occurs in the forearm and the hand after removal of the abduction splint. Corrective measures include active

(*Continued on page* 70)

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Physical Medicine (Continued)

exercises of the fingers, hand, and wrist, together with the use of sympathetic block.

The patient should return to light work for a period of several months before heavy labor is permitted. Depending upon his age and the state of degeneration of the cuff, it may be best permanently to avoid heavy lifting and also exertion above the horizontal plane. This tends to make the patient favor the limb, and there is little doubt that such cases could have the muscles trained to greater power by special exercise therapy.

THE EFFECT OF MICROWAVE RADIATION ON THE PERIPHERAL PULSE VOLUME, DIGITAL SKIN TEMPERATURE AND DIGITAL BLOOD FLOW IN MAN

Emery K. Stoner, M. D., M.Sc., Philadelphia. In ARCHIVES OF PHYSICAL MEDICINE, 32: 6:408, June 1951.

Sixty experiments were performed on 16 subjects to obtain data on the effects of microwave irradiation applied to the forearm on digital blood flow, pulse volume, and temperature. Various types of directors and different power output were utilized. The heating period of 30 minutes and the 5 cm. distance between the director and the skin were kept constant.

On the basis of the experimental evidence the following conclusions can be supported:

(1) Microwave irradiation of the forearm does not increase oral temperature or pulse rate.

(2) Vasodilatation is rapidly induced in both hands at the same time and to about the same degree.

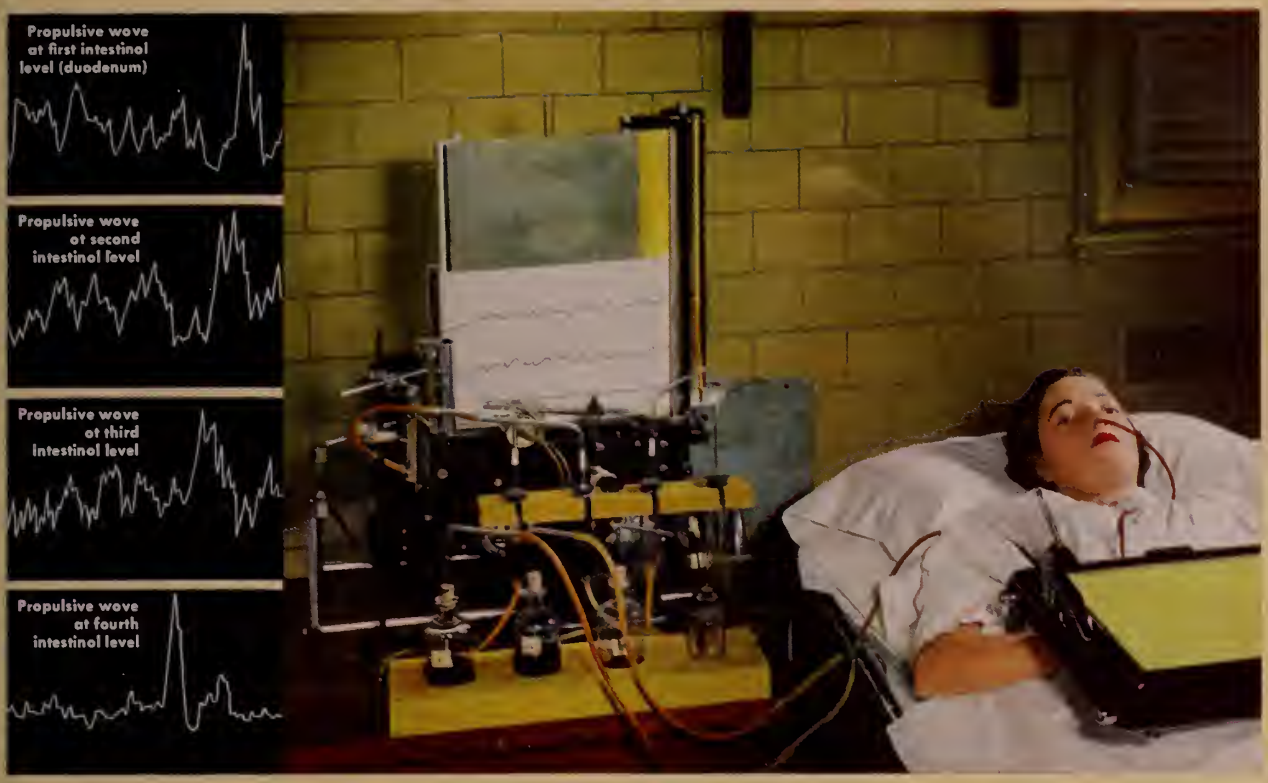
(3) Complete vasodilatation was not produced in any of our subjects by treatment with microwave.

(4) The changes in digital pulse volume, temperature and blood flow of the upper extremities in response to heating the forearm with microwave radiation were parallel and varied directly with the power output that was applied.

(5) Burns from microwave energy can be sustained with only minor discomfort during the time of exposure.

The goal of tuberculosis control must be recognition of the patient as a person and of the program as a coordinated community undertaking. In that way, tuberculosis control can fulfill its promise of trail blazer and road marker for the newer programs in public health. Pub. Health Reports, Joseph W. Mountin, M.D., February 2, 1951.





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REFERENCES: 1. Chapman, W. P., Rowlands, E. N., and Jones, C. M.: New England J. Med., 243:1, 1950. 2. Kramer, P. and Ingelfinger, F. J.: Med. Clin. North America, 32:1227, 1948. 3. Posey, E. L., Bargen, J. A., and Dearing, W. H.: Gastroenterol., 11:344, 1948.

FORMULA: Each tablet, each capsule, and each 5 cc. (1 teaspoonful) of Elixir, contains 0.1037 mg. hyoscyamine sulfate, 0.0194 mg. atropine sulfate, 0.0065 mg. hyoscine hydrobromide, and 16.2 mg. (¼ gr.) phenobarbital.

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REFERENCES: 1. Kammandel, H. et al.: Bull. N. Y. Med. Coll., Flower & Fifth Ave. Hosps. (in press). 2. McGavack, T. H. and Klotz, S. D.: Bull. N. Y. Med. Coll., Flower & Fifth Ave. Hosps., 9:61, 1946. 3. Weissberg, J. et al.: Am. J. Dig. Dis., 15:332, 1948.

FORMULA: Each tablet contains 300 mg. pancreatin, U.S.P., 250 mg. pepsin N.F., and 150 mg. bile salts.

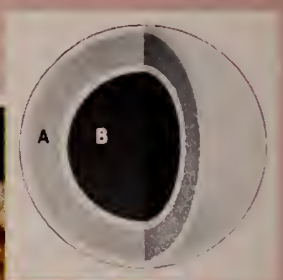
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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (Apr. 2,) 1949

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BOOK REVIEWS



A Textbook of Medicine — Edited by: Russell L. Cecil, M.D., Sc.D., Professor of Clinical Medicine, Emeritus, Cornell University, New York. Robert F. Loeb, M.D., Bard Professor of Medicine, Columbia University, New York. Associate Editors: Alexander B. Gutman, M.D., Professor of Medicine, Columbia University, New York; Walsh McDermott, M.D., Associate Professor of Medicine, Cornell University, New York; Harold G. Wolff, M.D., Associate Professor of Medicine (Neur.), Cornell University, N.Y. New, 8th Edition. 1627 pages, 204 figures, 40 tables. Philadelphia and London: W. B. Saunders Co., 1951. Price $12.00.

This is another revision of this well known standard textbook of medicine for students and practitioners.

Considerable new material has been presented. There have been some transpositions of material as for example, Infectious Mononucleosis has been placed in the section on Viral Diseases.

Eighty two new treatises on subjects previously covered have been necessary as the result of death or retirement of former contributors.

The rearrangement and editing of this edition has shortened it by 136 pages without sacrificing any important material and many color plates are included.

J. W. P.

Recent Advances in Chemotherapy — 3rd Edition — Volume 1 — By G. M. Findlay, C. B. E., Sc.D., M.D., F. R. C. P., Editor, Abstracts of World Medicine and Abstracts of World Surgery, Gynaecology and Obstetrics, British Medical Association, London. 625 pages. June 14, 1950. The Blakiston Company, Philadelphia. $7.50.

The remarkable progress in chemotherapy since the introduction of the sulfanamides in 1935 by Domagk has necessitated the enlargement of this work from one to four volumes. This first volume deals with the chemotherapy of scabies and of helminthic and protozoal diseases with the exception of malaria.

Continuing rapid advances in medicine make it difficult for a book like this to be up to date. However, this volume contains all necessary basic information, complete and well presented, and thus fills a definite need. One disadvantage to the American reader is inherent in the subject rather than the book: this is the nomenclature, the many different names given the same chemotherapeutic agents by pharmaceutical committees and proprietory firms. The author has given as many names as possible but, as he suggests, standardization is a matter for an organization like the World Health Organization.

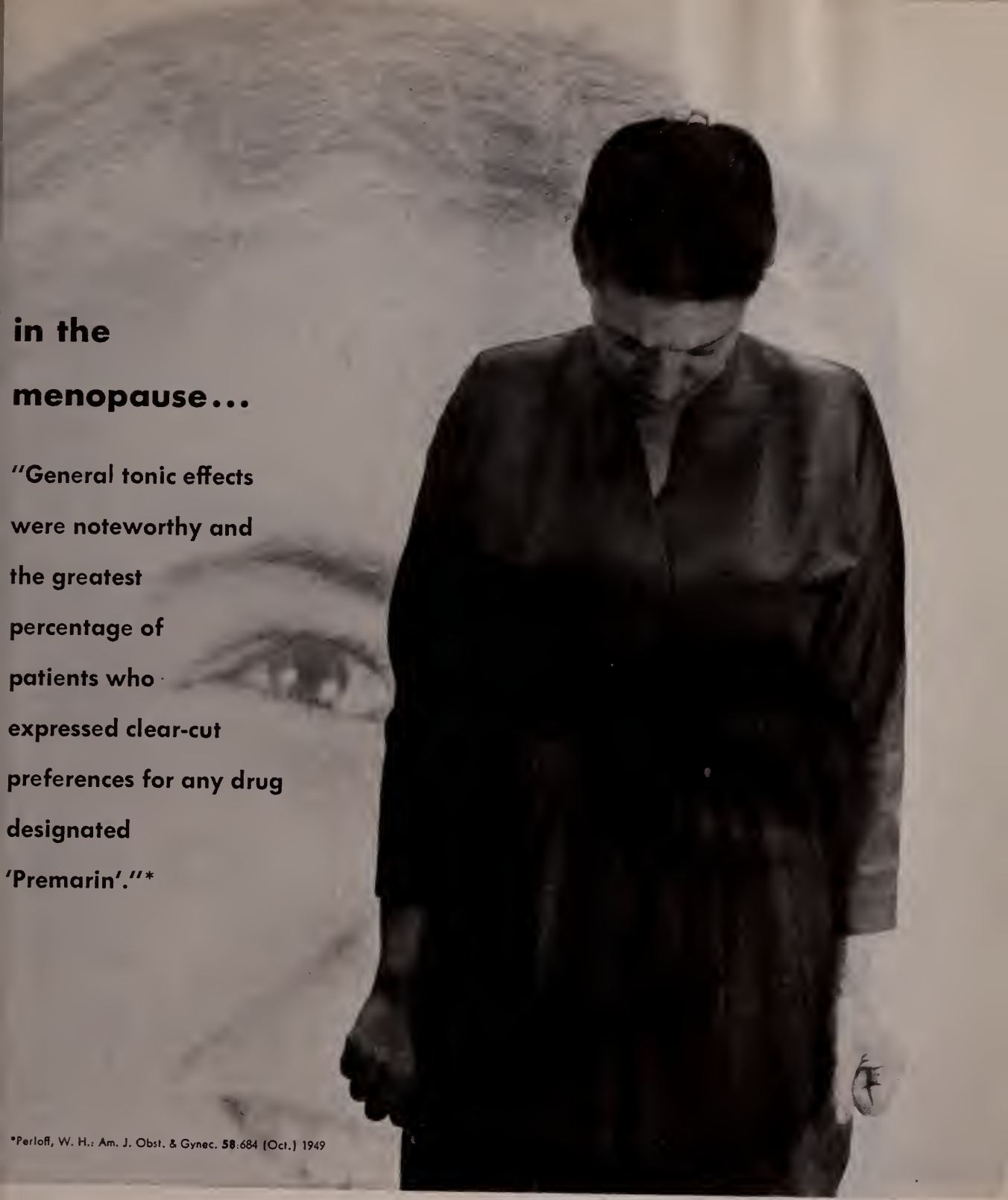
J. C. S.

The Foot And Ankle. Philip Lewin, M.D., F.A.C.S. Lea & Febiger, 847 pp., 389 illustrations. $11.00.

This is the third edition of an excellent treatise on the foot and ankle in its fullest meaning. Many small tables are included which outline the subject quite thoroughly and cut down on a lot of explanation and also tends to impress the reader more with this style. The anatomy and physiology of the foot are taken up in detail so that as we progress through succeeding chapters in the book the pathological changes are taken up and discussed and treatment advised.

Fractures and dislocations of many bones and joints of the foot are gone into very thoroughly. An outline is presented whereby an estimation of foot and ankle disabilities may be determined based upon the normal function of the foot and ankle disorders. Credit is very liberally given to outside help and authors for their work on the subject presented. Practically all the diseases which affect the body and particularly those

(*Continued on page* 76)



in the menopause...

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949

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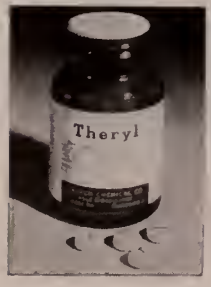
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1. Hoffman, Murray M., Ill. Dent. Jl., 19:439-445 (Oct., 1950)

2. McNealy, Raymond W., Ill. Med. Jl., 97:150 (Mar., 1950)

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BOOK REVIEWS (Continued)

affecting the foot and ankle location are considered from the point of view of the foot and ankle, the only exceptions are when treatment of the body as a whole must be considered.

There is a very comprehensive chapter on tumors of the bones, joints, soft tissues, tendon sheath and primary tumors of the foot and ankle. Plantar warts, corns, ringworm of the foot and other common conditions are presented in detail including the treatment.

The chapter on surgical technique is particularly illuminating and presents many good points which could well be followed by the surgeon doing this type of work.

The book as a whole is an excellent text.

R. J. B.

Trephine Technique of Bone Marrow Infusions and Tissue Biopsies: By Henry Turkel, B.A., M.A., M.D. Fourth Edition. Gale Printing Company, Detroit, Michigan. 60 pages. Price $1.00.

This is a most practical monograph. It describes the simple apparatus necessary and the techniques for intramedullary infusions through the sternum, tibia, femur and iliac crest.

Using the same apparatus, methods are described for obtaining biopsies from not only bone marrow but also soft tissue sites such as the prostate, lymph glands, breast and liver.

A detailed bibliography is included in the final chapter concerning infusions and biopsies.

J. W. P.

A. M. A. Primer on Fractures. Frederick A. Jostes, M.D., Gordon M. Morrison, M.D., Kellogg Speed, M.D. Paul B. Hoeber, Inc. 109 pp., 48 illustrations. $2.00.

The sixth edition of this practical little book is written under the able supervision of Frederick A. Jostes, M.D., St. Louis, Gordon M. Morrison, M.D., Boston, and Kellogg Speed, M.D., Chicago.

The terms "open" and "closed" fracture have been permanently established. The book serves very well for short concise use by students and practitioners. Practically all of the major fractures and the more common fractures are discussed and treatment is advised. Short concise tables are presented to simplify this great field of treatment. There are approximately 50 pages of tables, discussions and charts which very ably cover each of these important subjects. This very valuable little book is recommended to all students and practitioners.

R. J. B.

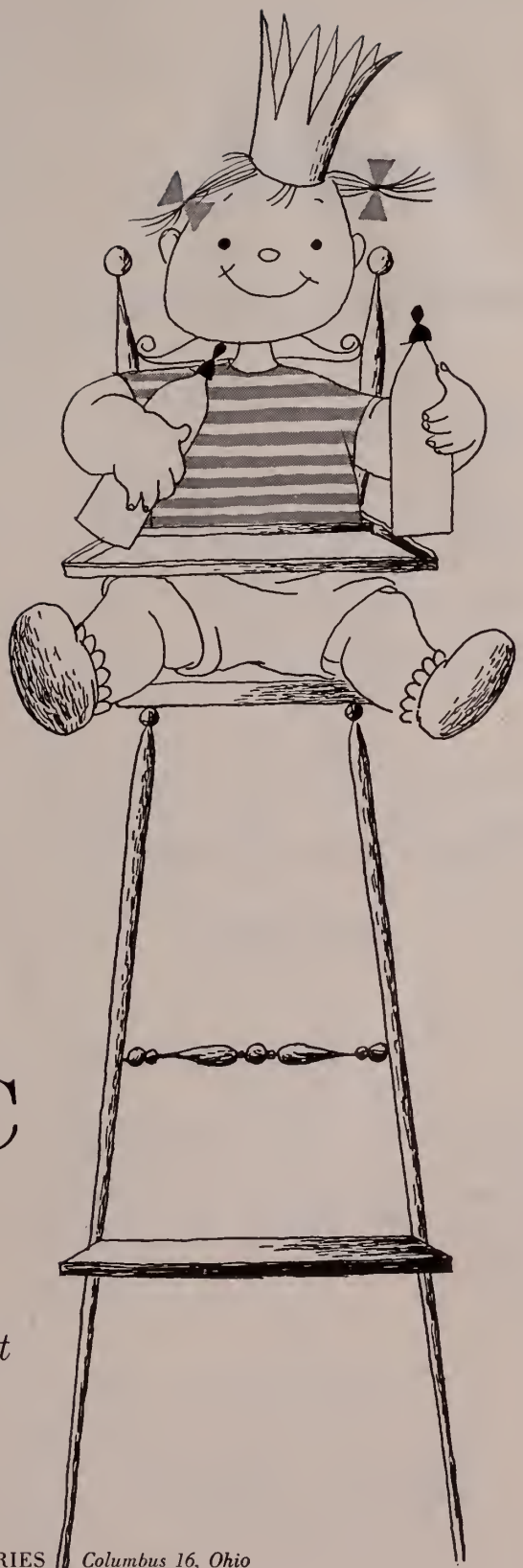
Surgery Of The Shoulder. A. F. DePalma, M.D. J. B. Lippincott Company, 438 pp., 454 illustrations. $17.50

This is a beautifully written book with large clear

(*Continued on page* 78)

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BOOK REVIEWS (Continued)

figures. The book starts out with comparative and then normal anatomy. A great many figures are taken from other texts. A large series of shoulders were obtained from different sources for study of the normal and pathological. This chapter is exceptionally well illustrated with photographs of the shoulder joint.

The chapter on complete and incomplete tears of the musculotendinous cuff is well handled in the text by photographs, x-rays and by drawings. The treatment of this condition is very conservative and results appear satisfactory.

The frozen shoulder is taken up in detail, and a reasonable explanation and treatment given. There is a long chapter on dislocations of the shoulder joint. Fractures and fracture-dislocations of the upper end of the humerus are well handled and with beautiful x-rays.

Shoulder pain of neurogenic origin is discussed very much in detail including the scalenus anticus syndrome and obstetric paralysis.

There is a very good chapter on bone tumors and a very comprehensive chapter on operative procedures and resections.

R. J. B.

Regional Orthopedic Surgery. Paul C. Colonna, M.D. W. B. Saunders Company, 706 pp., 474 illustrations. $11.50.

This book is a reflection of the personal experiences of the author over a period of years. The basic facts about bones and joints are first presented and then the abnormal conditions are considered. This pathology of bones and joints again is the result of experience of the author and is an excellent treatise on the subjects presented.

The chapter on the hip and pelvic ring is particularly well done and the methods outlined are very dogmatic yet considerate of the patient and the end result obtained.

There is a very interesting chapter on Neuromuscular disabilities.

The chapter on tumors of the bone is not too different from the experience of other authors.

A very interesting chapter is presented on principles of apparatus.

Physical medicine is presented with the views that it will aid in the care and treatment of the orthopedic surgery patient.

The book is well done.

R. J. B.

For a sick man or woman disease is an acutely personal problem, but it is also a communal problem. And if the public is to cooperate with the medical profession in the treatment of disease in the individual it will, we believe, be able to do this more intelligently if it has some idea of the size of the problem to the nation at large. Tuberculosis is an obvious example. The medical profession is only too well aware of the personal tragedies that have been caused by the purveyors of quack remedies for such dangerous diseases as cancer. Brit. Med. J., Ed., March 17, 1951.







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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

TOBACCO AND THE CARDIOVASCULAR SYSTEM — The Effects of Smoking and of Nicotine on Normal Persons. By Grace M. Roth, Ph.D., Associate Professor of Experimental Medicine, Mayo Foundation for Medical Education and Research Graduate School, University of Minnesota and Consultant in Section on Physiology, Mayo Clinic, Rochester, Minnesota. Charles C. Thomas, Publisher, Springfield, Illinois. 66 pages. $2.25.

MANUAL THERAPY. By James B. Mennell, M.A., M.D., B.C., (Cantab.) Consulting Physician in Physical Medicine, St. Thomas's Hospital, Vice-President and Hon. Fellow, Chartered Society of Psysiotherapy, London, England, Gold Key of the American Congress of Physical Medicine, Gold Key of the American Physical Therapy Association, Honorary Life Member of the Netherlands Physical Therapy Association. 64 pages. $2.25.

THE MANAGEMENT OF FRACTURES, DISLOCATIONS, AND SPRAINS. By John Albert Key, B.S., M.D., St. Louis, Missouri, Clinical Professor of Orthopedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's, and Jewish Hospitals, and H. Earle Conwell, M.D., F.A.C.S., Birmingham, Alabama, Associate Professor of Orthopaedic Surgery, University of Alabama School of Medicine; Chief of the Orthopaedic Service, South Highland Infirmary; Consulting Orthopaedic Surgeon to Carraway Methodist Hospital and Baptist Hospitals; Attending Orthopaedic Surgeon, Children's Hospital, Jefferson-Hillman Hospital, East End Memorial Hospital, and St. Vincent's Hospital, Birmingham, Alabama. Fifth Edition. The C. V. Mosby Company, St. Louis, Missouri. 1232 pages. $16.00.

REVIEW OF PHYSIOLOGICAL CHEMISTRY. By Harold A. Harper, Ph.D., Professor of Biology (Biochemistry), University of San Francisco, Lecturer in Surgery, University of California School of Medicine, San Francisco, Biochemist Consultant to Metabolic Research Facility, U. S. Naval Hospital, Oakland, Director, Biochemistry Laboratory, St. Mary's Hospital, San Francisco. Third Edition. University Medical Publishers, P. O. Box 761, Palo Alto, California. 260 pages. $3.50.

LOW SODIUM DIET — A Manual for the Patient. By Thurman B. Rice, A.M., M.D., Professor of Public Health, Indiana University School of Medicine, Indianapolis, Indiana. Lea & Febiger, Philadelphia, 1951. 103 pages. 14 Food Charts. $2.75.

(*Continued on page 82*)

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1. Best, C. H.; Lucas, C. C.; Patterson, J. M., and Ridout, J. H.: Lipotropic Properties of Inositol, Science *103*:12 (Jan. 4) 1946.

2. Dolan, R. A.: Choline and other Lipotropic Factors: Mechanisms of Action and Significance in Chronic Liver Disease, Minnesota Med. *31*: 1198 (Nov.) 1948.

3. Goldstein, M. R., and Rosahn, P. D.: Choline and Inositol Therapy of Cirrhosis of the Liver, Connecticut M. J. *9*:351 (May) 1945.

4. Cogswell, R. C.; Schiff, L.; Safdi, S. A.; Richfield, D. F.; Kumpe, C. W., and Gall, E. A.: Needle Biopsy of the Liver, J.A.M.A. *140*:385 (May 28) 1949.

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BOOKS RECEIVED (Continued)

METABOLIC METHODS — Clinical Procedures in the Study of Metabolic Functions. By C. Frank Consolazio, Chief of Biochemistry, United States Army, Medical Nutrition Laboratory, Chicago, Illinois, and Robert E. Johnson, M.D., D. Phil. (Oxford), Professor and Head of the Department of Physiology, University of Illinois, Urbana, Illinois, and Evelyn Marek, M.A., Biochemist, United States Army, Medical Nutrition Laboratory, Chicago, Illinois. Illustrated. The C. V. Mosby Company, St. Louis. 471 pages. $6.75.

A TEXTBOOK OF MEDICAL CONDITIONS FOR PHYSIOTHERAPISTS. By Joan E. Cash, B.A., M.C.S.P., (Teachers' Certificates). with a foreword by Frank D. Howitt, C.V.O., M.A., M.D., F.R.C.P., J. B. Lippincott Company, Philadelphia, London, Montreal. 350 pages. $5.00.

CLINICAL PEDIATRIC UROLOGY: By Meredith Campbell, M.S., M.D., F.A.C.S., Professor of Urology, New York University, Post-Graduate Medical School. With a Section on Nephritis and Allied Diseases in Infancy and Childhood; by Elvira Goettsch, A.B., M.D.; and John D. Lyttle, A.B., M.D., 1113 pages with 543 figures. Philadelphia and London: W. B. Saunders Company, 1951. $18.00.

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The prevailing cross section of opinion is that a small percentage of inguinal hernias will cure spontaneously during the first year of life, and that an occasional cure can be expected even to the age of 2½ years. The term "cure" should be used in the sense that during the period of observation the hernia no longer protrudes. Failure to observe a protrusion does not necessarily mean a "cure" but, instead, may be due to the fact that the infant is almost always in a position of recumbency which favors reduction of the hernia, or that conditions at the time of observation do not favor herniation into the sac. Evidence points to the conclusion that true complete obliteration of the hernia sac after birth probably does not occur. Instead, the canal remains patent, waiting for conditions to become more favorable for refilling. These conditions include weakening of the surrounding musculature and increase in intra-abdominal pressure, and they may not arrive until years later. Cases of inguinal hernias of infancy and childhood have been written off as spontaneously cured,

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Few diseases have shown the continuous, yearly decline in mortality exhibited by tuberculosis. Mortality from tuberculosis continued to decline in 1949, when 39,000 deaths from all forms of the disease occurred in continental United States. The death rate is estimated to be 26.2 per 100,000 population, excluding the armed forces overseas. Evelyn H. Halpin and Otis D. Turner, Pub. Health Rep., May 4, 1951.

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Physicians should realize that their office is not only a place in which to transact the business of medicine but is also a place in which much material and spiritual relief can be given — then medicine again becomes a profession. *Excerpt: Keeping Up With Medicine, Jonathan Forman, M.D., Editor, O.S.M.J., May 1951.*

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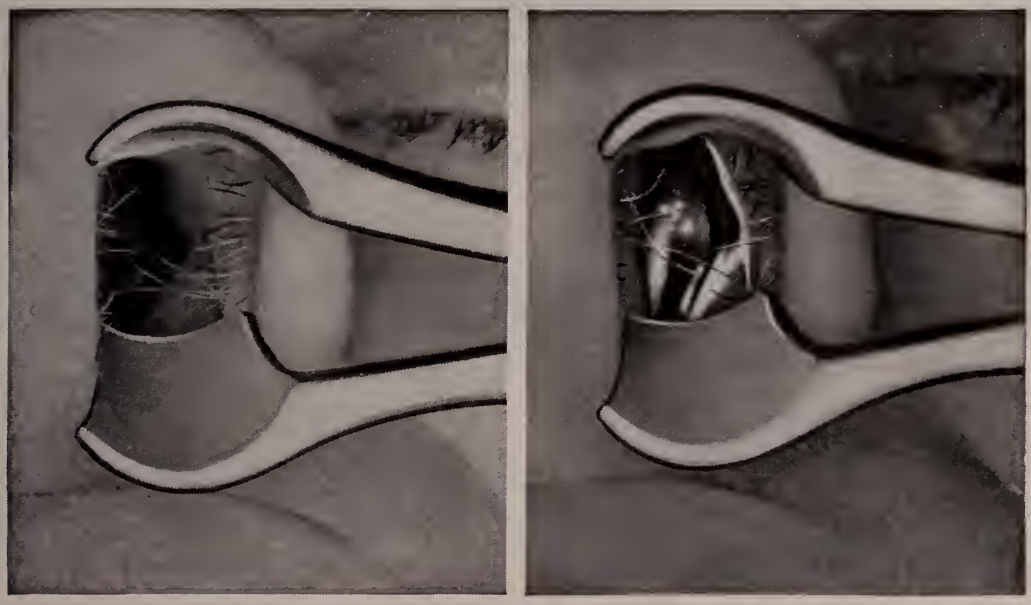
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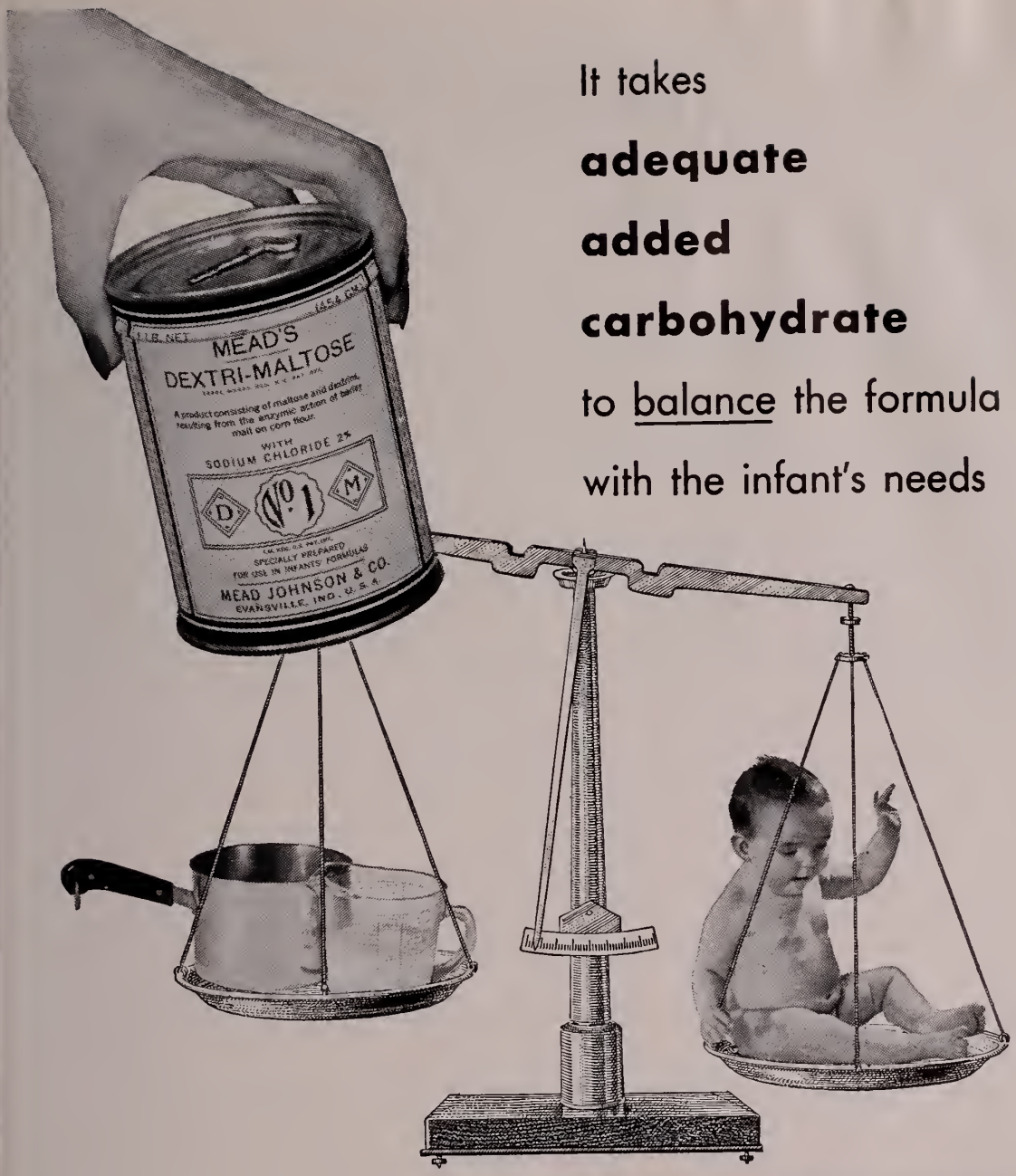
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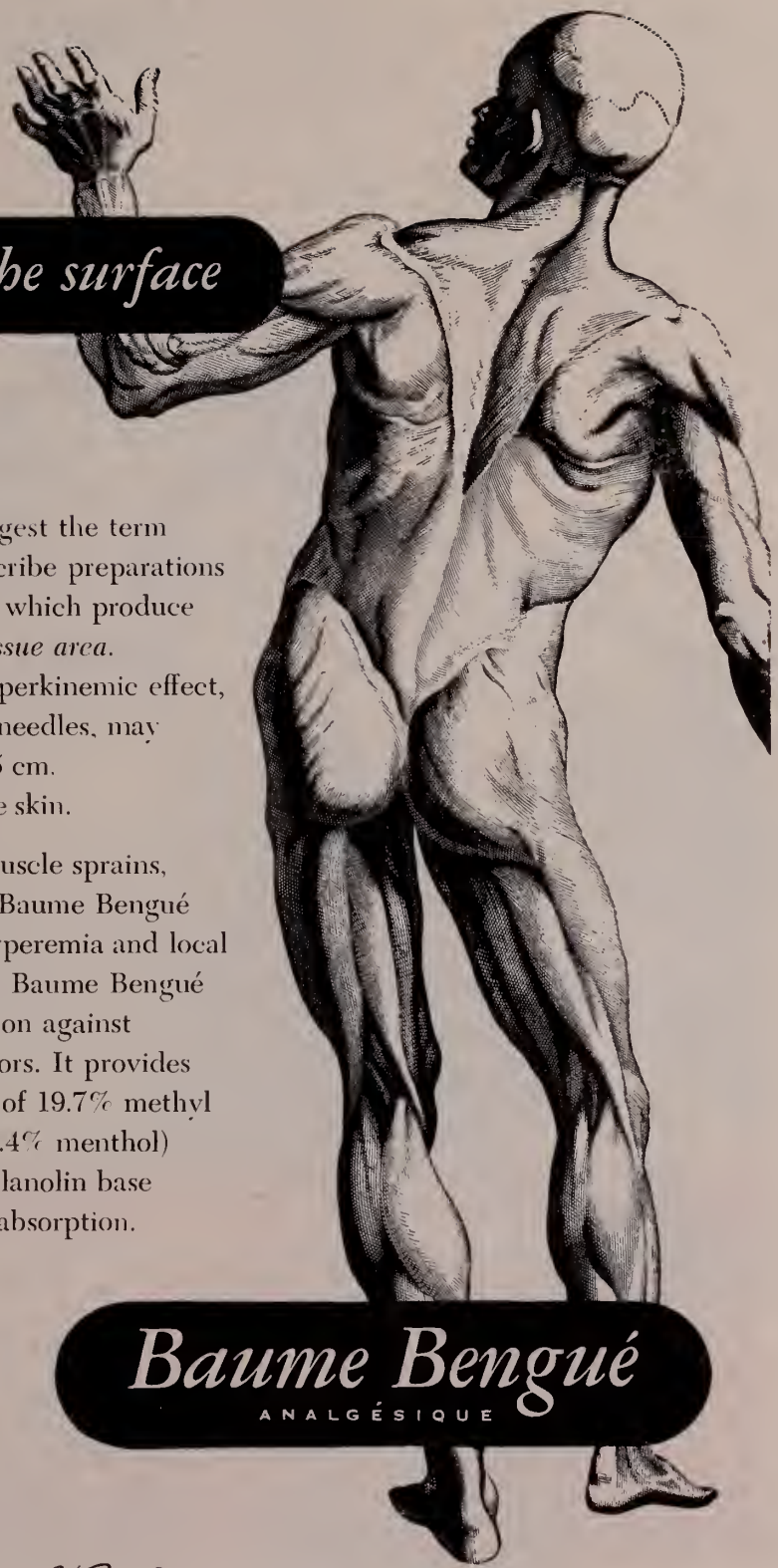
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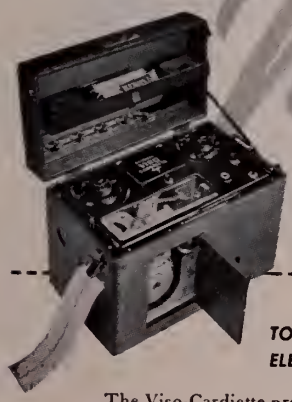
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2. *Upham, R., and Chaikin, N. W.: Rev. Gastroenterol. 10:287, 1943.*
3. *Collins, E. N.: J. A. M. A. 127:890, 1945.*

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1. Williams, P. F., and Fralin, F. G.: *Am. Jour. Obst. & Gynec.*, 43:1, Jan., 1942.
2. Wahl, M. G., and Schneeberg, N. G.: In Jolliffe, Norman, et al.: Clinical Nutrition, New York, Hoeber, 1950, p. 684.

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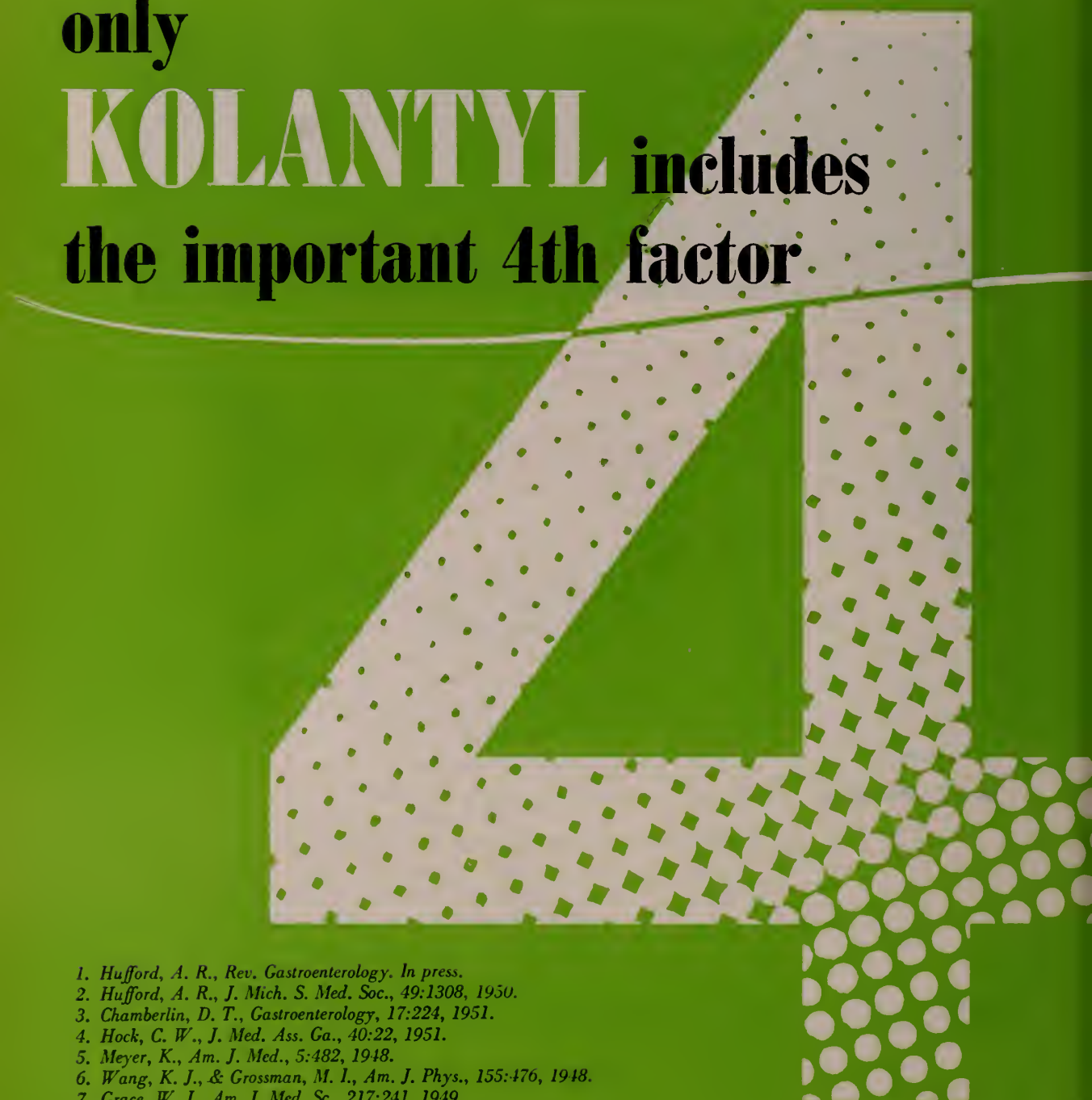
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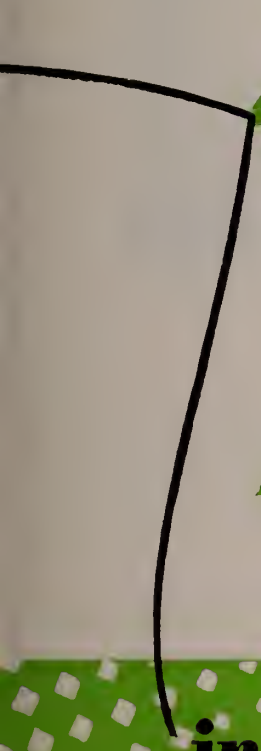
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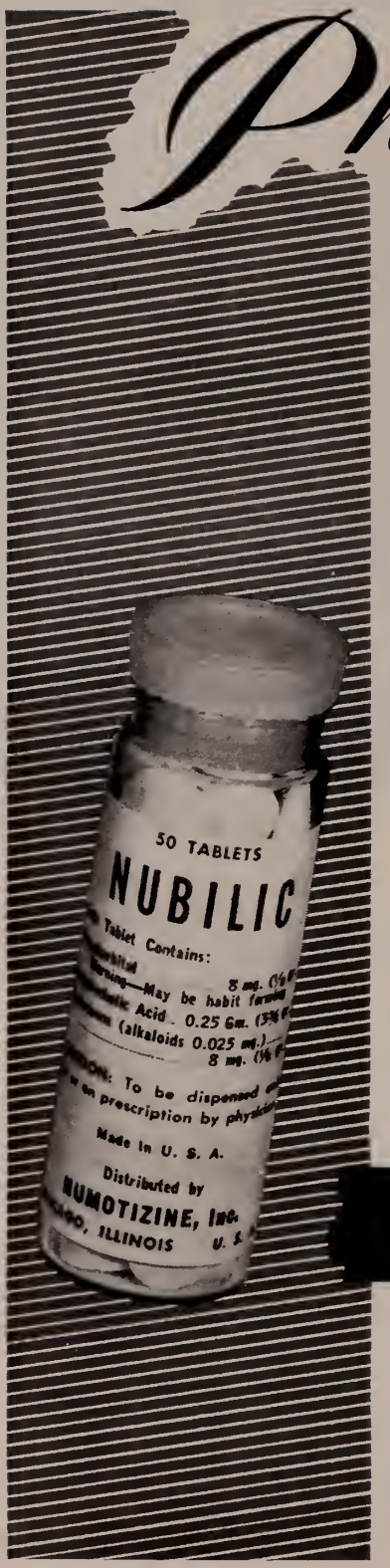
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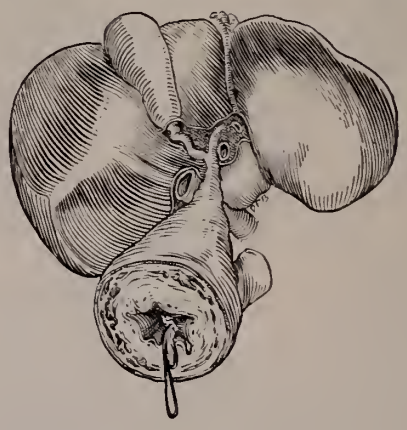
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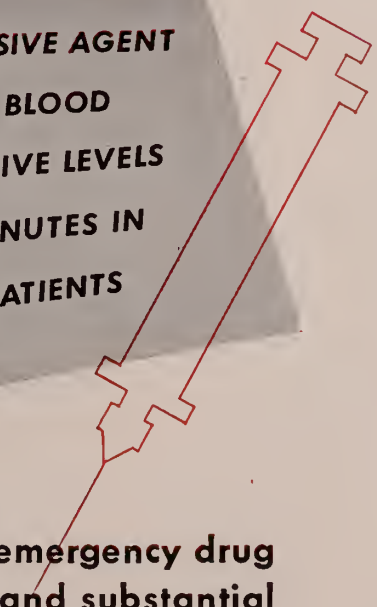
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1. Anspaugh, R. D.: Effects of Dexedrine Sulfate on Nausea and Vomiting of Pregnancy, Am. J. Obst. & Gynec. 60:888 (Oct.) 1950.



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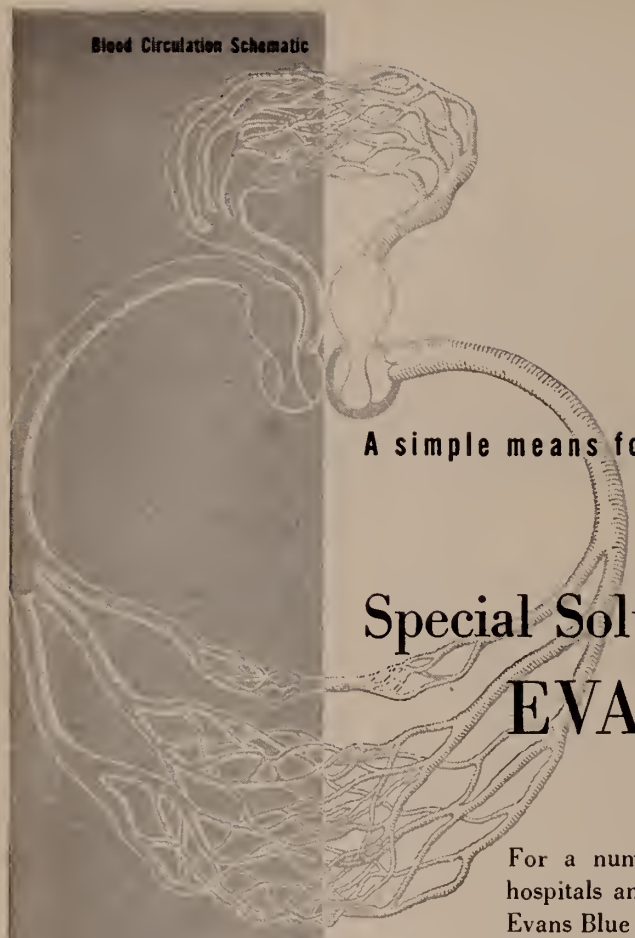
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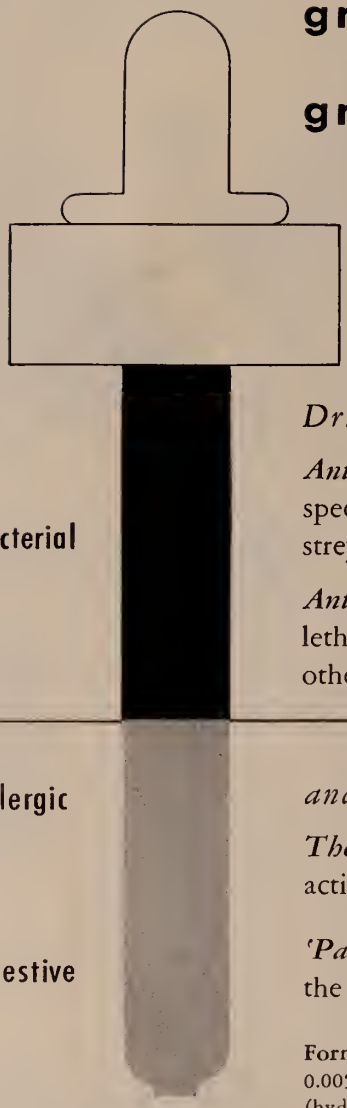
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1. Vollmer, H., Pomerance, H., and Brandt, K. (1950), Treatment of Pneumonia with a Single Oral Dose of a Penicillin-Sulfadiazine-Sulfamerazine Combination, N. Y. State J. Med., 50:2293, Oct. 1.

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*Reference: MacBryde, C. M., et. al., A New Synthetic Estrogen, J.A.M.A., 123: 261: 264-(10-2) 43.

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FOLIC ACID		**1.67** milligrams	**0.28** milligrams	**0.28** milligrams
IRON			**220** milligrams ferric ammonium citrate	**130** milligrams ferrous sulfate exsic.
VITAMIN C				**50** milligrams
DOSAGE THERAPEUTIC	15 to 30 micrograms daily for a week or more; when neurologic involvement is present, 50 micrograms or more daily.	1 or 2 capsules daily	2 teaspoonfuls t.i.d.	2 capsules t.i.d.
MAINTENANCE	Generally, 30 to 50 micrograms twice a month; when neurologic involvement is present, 50 micrograms a week.	1 capsule daily	1 teaspoonful t.i.d.	1 capsule t.i.d.
SUPPLY	1 cc. ampuls, 15 & 30 micrograms of vitamin B_{12} per ampul. 5 & 10 cc. vials, 30 micrograms per cc. 10 cc. vials 50 micrograms per cc.	Bottles of 100	Pint and gallon bottles	Bottles of 100

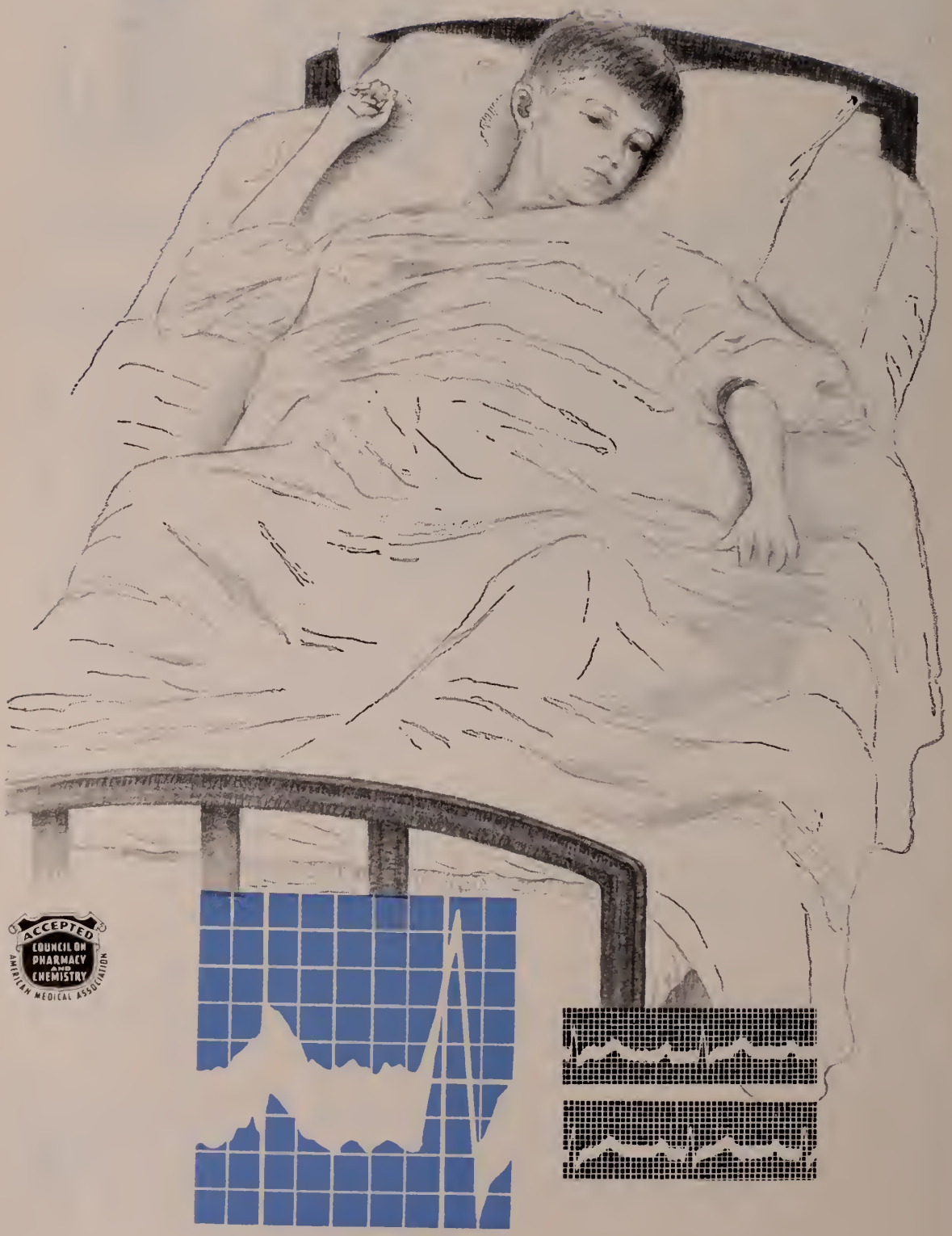
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ACTHAR, in an increasing number of rheumatic fever patients, has shortened the course of the disease, minimized residual cardiac damage and probably reduced mortality. Systemic signs and symptoms of rheumatic fever usually disappeared within three days—the acute rheumatic process was brought under control, and the electrocardiogram and enlarged heart returned to normal, with regression of pathologic murmurs. Marked cardiac failure, however, necessitates special caution, since sodium and water retention may be produced.

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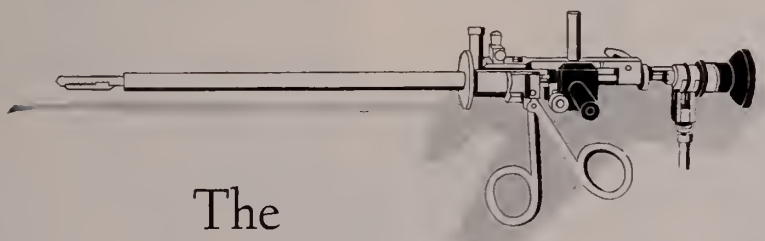
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The
ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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Vol. 100, No. 4 October, 1951

MALARIA — A MILITARY PROBLEM

Malaria continues to be a military problem even though fighting is confined to Korea. The clinical phase appears to be "licked" and several drugs now are available which will completely eliminate the most severe symtoms of malaria. The permanent cure of the temperate zone variety (which is most common in Korea) still is lacking. The stumbling block is the tissue phase of malaria. It is at this time that the parasites are harbored in the cells of the liver and other organs of the body and no symptoms are evident. This period is different from the clinical phase during which the parasites rupture the red blood cells and cause chills, fever and severe headache.

For many years, quinine was the only drug available to control the clinical phase. At the close of World War II, the Army had in atabrine an effective suppressant which proved as effective, if not more so than quinine. But these drugs had certain disadvantages and were ineffective also against the parasite during the tissue phase. In 1947, chloroquine was introduced as the most superior antimalarial drug to be discovered. It did not discolor the skin and had fewer "side effects." As a suppressant it was effective when taken only once a week instead of every day. It was said to be more efficient than atabrine and quinine in relieving the acute symptoms of diseases and eliminates the malarial parasites from the blood stream in as little as twenty-four hours. Unfortunately, the drug is neither a preventive nor a complete cure for malaria. This means that many of the returnees from Korea will experience chills and fever as soon as the suppressant action of the drug disappears.

During the last few years newspapers have carried many stories on a new and promising substance which is being used on prisoner volunteers at Statesville Penitentiary, Joliet, Illinois, in cooperation with the University of Chicago. This product, primaquine, was found to be most effective in the laboratory against experimental strains and it is hoped that it will prove as deadly against the strain of malaria found in Korea.

It is important to note that primaquine also is effective against the tissue phase of the disease because it is capable of dealing with the stubborn parasites in the liver cells. At the present time, it is being used in Korea. It is possible that this study will be one of the most important research projects to emerge from this war. If so, we will be able in the future to effect rapid cures from malaria and prevent numerous relapses by treating simultaneously the parasites in the blood stream with chloroquine and those in the liver with primaquine.

There have been no improvements in the prevention of malaria since World War II. Materials used included DDT, aerosol sprays, newer

repellents, and the standardization of atabrine and now chloroquine as a malarial suppressant. An intensive educational program must continue because prevention requires cooperation and cooperation is stimulated by education.

HOME CARE OF POLIO PATIENTS

In the light of present knowledge it is quite obvious that all patients with poliomyelitis do not need to be hospitalized. The decision depends of course, on the severity of the illness, the actual home conditions, and the availability of community resources. Realizing that hospitalization today is expensive, and that hospital beds should be made available for emergency conditions, it is not only a saving to the family of the patient, but likewise a service to those patients who must be hospitalized.

The decision as to whether or not hospitalization is advisable should be left primarily to the attending physician. If there is a suspicion that the infection is likely to become a respiratory or bulbar type, the patient needs to be immediately hospitalized. There is probably but little more, if any greater danger of infection in other members of the family, so sending the patient to the hospital does not guarantee protection for those remaining at home.

It is generally recognized however, that the clinical picture in early poliomyelitis can change rapidly, and it is essential that the physician be readily available if the decision is for home care. Likewise the availability of a satisfactory hospital is an important factor in making decisions. The economic status of the family is an important factor, and their willingness to cooperate should be taken into consideration. Again the availability of community resources which, when assistance is needed, are readily forthcoming is quite important. Sanitary facilities must be satisfactory; an inside toilet, proper care of all discharges from the patient, the essential handwashing of those in attendance are all important.

When available, the services of a part time, or visiting nurse are desirable for home care. The local chapter of the National Foundation for Infantile Paralysis usually furnishes the necessary additional financial aid.

In those cases where early hospitalization seems desirable until the acute stage is past, it is often possible to take the patient home for the convalescent care, with the previously mentioned services and precautions ever kept in mind. An organized physical therapy home visiting service is desirable so that the treatment begun in the hospital can be continued in the home. A careful evaluation of the home situation is of great importance, and rather frequent conferences on the part of the physician and therapist are advisable.

The National Foundation for Infantile Paralysis through its local chapters pays for professional services in the home, such as physical therapy or nursing, provided the service is given by a recognized community agency.

Physical therapy is a highly important part of a home care program and it is possible for the therapist to instruct members of the family to give the treatments as often as seems desirable. The family members to give this convalescent care should be thoroughly instructed as early as possible, and they should be told not only the technic but what is hoped to be accomplished through this care. As for the length of time during which this care should be given is still rather indefinite, but a minimum of one year from the onset is usually advisable. In some cases it is continued for some time after the end of one year, as long as it is reasonable to suspect that further benefit can be gained.

The home care program when deemed safe, has definite psychological advantages, permitting the patient to be among other members of the family, and aids materially in improving the parent-child relationship. The Medical Department of the National Foundation for Infantile Paralysis has pamphlets and other information of value to the family of patients with this disease, and they can be procured by writing to the Medical Department, Division of Professional Services, 120 Broadway, New York 5, New York. Information can be received relative to the giving of hot packs in the home, the proper methods of preparing the bed for the poliomyelitis patient, and other information of value to those who will be responsible for giving the proper care, and obtain the maximum results for the patient.

YEARN TO LOSE

A recent Gallup poll disclosed that one out of every three adults in the United States wants to lose weight.

ILLINOIS PHYSICIANS AT MID-WEST CONFERENCE

Several members of this society will figure prominently on the program of the Nineteenth Annual Assembly of the Omaha Mid-West Clinical Society, to be held October 29 to November 2, inclusive, at the Hotel Paxton, Omaha, Nebraska. According to the August issue of the Journal of the Omaha Mid-West Clinical Society, Drs. Roland P. Mackay, Louis R. Limarzi, Louis N. Katz, and Vincent J. O'Conor, all of Chicago, are scheduled to appear on the program. Many other distinguished guests who are eminent in their particular specialty fields will address the assembly and conduct clinics and question and answer periods. Lectures, panel discussions, scientific exhibits, scientific motion pictures and technical exhibits are also being arranged.

The annual postgraduate assemby of the Omaha Mid-West Clinical Society was the first regional meeting to receive a Class A rating by The American Academy of General Practice.

MALARIA IN VETERANS

Leonard M. Schuman, M.D., M.Sc., Deputy Director, Division of Preventive Medicine Illinois Department of Public Health

The U. S. Public Health Service has advised the Illinois Department of Public Health that a significant incidence of vivax malaria has been noted among veterans returning from the Korean Theater. Several such cases have already occurred among veterans returning to Illinois. There will undoubtedly be more. We, therefore, would like to call your attention to the possibility of this disease among such patients coming into your practice.

Most cases of malaria among returning veterans were undoubtedly contracted in Korea last fall. In some instances, a prolonged incubation period or suppressive medication has tended to delay manifestation of symptoms until this spring. In others, relapses following earlier treatment may occur.

Attacks of vivax malaria are thus occurring among such veterans after their return to this country and while on leave or after separation. Thus, many will not be under military supervision at the time of their attack or recurrence.

The attack may be preceded by malaise or headache but usually begins abruptly with a violent shaking chill followed by fever and sweating. Fever lasts for several hours. The patient then feels well for 48 hours when the next rigor occurs. Variations in the periodicity of the disease may occur, however, and may be due to variations in immunity and plasmodial strains. Recurrent attacks lead to mild jaundice and occasionally enlargement of spleen and liver.

Diagnosis of malaria is *entirely* dependent on the demonstration of the parasite in stained blood smears. *Thick* blood smears enhance the discovery of the parasites. Physicians are urged to utilize the laboratories of the Illinois Department of Public Health for this purpose. Controversial slides will be submitted to the National Depository for Malaria Slides of the U. S. Public Health Service Communicable Disease Center for examination by consultants. This Center has been designated by the National Malaria Society.

It is imperative by the Rules and Regulations of the Department of Public Health that all cases of malaria be reported promptly to full-time local health departments or, in unorganized areas, to this Department in Springfield. This applies to military malaria as well as indigenous malaria since both can constitute a potential hazard of spread and lead to the re-establishment of endemic areas of the disease. Anopheles quadrimaculatus does exist in Illinois and may serve as the vector of spread.

Reporting to the health department which maintains vigilance on the mosquito vectors is thus a necessary first step in control of the disease for only upon notification of instances of malaria can practical decisions be made as to insecticide spraying of the environs of the case or the need for more extensive community spraying.

Modern antimalarials are now available for therapy and will alleviate symptoms promptly. Some patients completing courses of these drugs will remain free from malaria but others may relapse after weeks or months. All patients should be so advised that they may seek medical care if symptoms recur. The likelihood of clinical reactivation becomes less with passage of time. Relapses are rare after the second or third attack.

1. ACUTE ATTACKS OF MALARIA — Chloroquine, quinacrine, chlorquanide and quinine in adequate dosage will usually stop acute attacks. *Chloroquine* is by far the superior drug in many respects, including paucity of side-actions.

 DOSAGE: *Chloroquine* diphosphate: Initial dose 1.0 gram orally followed by 0.5 gm six hours later, then 0.5 gm once daily for two days.

2. CURE OF VIVAX MALARIA — Relapsing vivax malaria lends itself to radical cure by use of a combination of quinine plus pentaquine, isophentaquine or pamaquine. Pentaquine offers the greatest margin of safety.

 DOSAGE: *Pentaquine phosphate*: 60 mgm orally per day (10 mgm every 4 hours) with 2 grams quinine sulfate daily for 14 days.

MEDICAL ECONOMICS COMMITTEE SEEKS ADVICE

An article on the subject of Medical Economics appeared in the September issue of the Illinois Medical Journal. This was written by the present chairman of the Society's committee, Dr. John R. Wolff, 30 North Michigan Avenue, Chicago 2, Illinois. Dr. Wolff gave a short history of the development of the Committee, and those who have been responsible for its articles published monthly in the Journal for some 18 years.

Realizing that we are living in an ever changing world, and that the principal problems in medical economics are constantly changing, the Committee will appreciate receiving suggestions from members of the State Society as to what subjects they would prefer to have discussed in future issues of the Journal. Medical Economics embraces a wide field, and it deals not only with the many problems relative to improving medical care, but likewise improving the relationship between the physician and patient. Today it is closely interwoven with the many problems in medical public relations.

Such problems as better arrangements for night and emergency calls, care of the transients, rural medical services, group practice, services in state hospitals, and many other equally important subjects will be discussed in succeeding issues of this Journal each month.

It is hoped that many members of the Illinois State Medical Society will write to Dr. Wolff as chairman of the Committee, and tell him what subjects particularly they would prefer to have presented in the Committee's section of the Journal. As Dr. Wolff expresses it, the committee solicits suggestions, criticisms, in addition to any aid you can give them. It is their intense desire to make the department in the Journal exactly what you would like to have it to be, and suggestions will be welcomed at any time.

PORPHYRIA

Porphyria is a metabolic disease characterized by excessive excretion of porphyrins in the urine and feces. Clinically it appears to occur in two forms, congenital and acute. Congenital porphyria is rare and is distinguished by red discoloration of the teeth and bones and by photosensitivity of the skin. The acute form is much more common. It is actually a chronic disease characterized by remissions and exacerbations, with symptoms involving principally the nervous and gastrointestinal systems. Both forms are thought to be hereditary, the congenital being transmitted as mendelian recessive and the acute as mendelian dominant. *Excerpt: Acute Porphyria, S. R. La Tona, M.D., N. Y., and Adrain Foe, M.D., Department of General Medicine, Cleveland Clinic Quarterly, July, 1951.*

CORRESPONDENCE



"YOUR MENTAL HOSPITALS" LIMITED MEDICAL LICENSE

Physicians from other states, or other countries, who are not licensed to practice medicine in Illinois may now obtain a limited license to practice in a specific state institution, if they possess the necessary qualifications.

This measure, which is expected to provide sorely-needed physicians for the state mental institutions, was enacted by the 67th General Assembly and was signed into law by Governor Stevenson on August 4, 1951.

No lowering of medical standards is contemplated under the new law; on the contrary, by making available additional qualified physicians, the measure should help to improve the medical care provided for the state's mental patients and other wards.

Briefly, the law provides that the Illinois Department of Registration and Education may issue the limited license to physicians who present satisfactory qualifications. To qualify, the physician must be a graduate of an approved school of medicine, either in the United States or another country. He must have a working knowledge of the English language.

The limited license, however, enables him to practice—in a specific state institution—until he can take the examination for a permanent license.

Doctors who qualify for limited licenses may be employed by the state as physicians or psychiatrists, at the professional level for which they would be eligible if they had a permanent license. Heretofore, doctors without a permanent Illinois license could be employed in state institutions only in a "medical student" classification.

The new law is expected to affect primarily two groups of physicians.

One group is made up of physicians from other states. If such a physician is licensed in his own state, he may qualify for a permanent Illinois license through reciprocal arrangements between the states. To qualify through this reciprocity arrangement, he must pass an oral examination or a practical examination given by the Medical Examining Board of the Illinois Department of Registration and Education.

As the Medical Examining Board meets only four times a year, a physician might be required to wait several months before qualifying for an Illinois license. With a limited license, however, he can be employed by a state institution with very little delay.

In addition, there are physicians from other countries who may want to delay taking the examination for an Illinois license because of language difficulties. Such a doctor may be quite able to carry on his day-to-day practice but may feel that his grip of the language is insufficient to carry him through an examination in which he will need speed and facility in

expressing himself.

The limited license is in no way intended as a substitute for the permanent license. All doctors will be urged to qualify themselves for the latter as soon as possible.

In adopting this measure, Illinois is following the lead of 19 other states that have already adopted legislation authorizing limited permits or licenses for physicians to work in state hospitals.

The Veterans Administration and the military forces, whose facilities extend throughout the country, allow a physician licensed in one state to practice in any one of the 48 states without obtaining a local state license.

The limited license law, we hope, will help to relieve the serious and critical shortage of doctors in the Welfare Department. At the time this measure was passed, there were, in the 12 mental hospitals, 201 physicians for 45,000 patients. Excluding the consultants who work several half-days a month, and the residents who are present for training, there were 142 fulltime physicians to care for the 45,000 patients—an average of one doctor for every 318 patients.

Especially in view of these facts, the Welfare Department urgently needs the services of physicians who can qualify for limited or permanent licenses. Physicians should apply to the Chief Medical Officer, Department of Public Welfare, Room 1500, 160 North LaSalle Street, Chicago 1, Illinois. (Telephone: FInancial 6-2000)

George A. Wiltrakis, M.D.

CANCER TERMINOLOGY STANDARDIZATION

The first major attempt to clarify and standardize the complicated terminology of cancer has been made by the American Cancer Society.

Publication of a new book, "Manual of Tumor Nomenclature and Coding," was announced recently by the Society. The book will be distributed to cancer clinics and registries, hospitals, health departments, medical schools, research centers, and to individual pathologists, surgeons and statisticians.

Widespread use of the new tumor code is expected since it will be used in conjunction with the American Medical Association's "Standard Nomenclature of Diseases" and the World Health Organization's "International Statistical Classification of Diseases, Injuries and Causes of Death."

Employment of the code will result in more comprehensive statistical records since it classifies both benign and malignant tumors according to histologic origin. Heretofore, most cancer death and incidence records have indicated only the body site of tumors. The final aim of statistical studies is to reflect organized knowledge back to the clinician for the patient's benefit.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR NOVEMBER

Twenty-one clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois Division of Services for Crippled Children. The Division will conduct 16 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical, social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The November clinics are:

November 6 — Shelbyville, Veterans Center

November 8 — Sterling, Sterling Public Hospital

November 8 — DuQuoin, Marshall Browning Hospital

November 8 — Springfield, St. John's Hospital

November 8 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

November 9 — Chicago Heights (Rheumatic Fever), St. James Hospital

November 13 — Peoria, St. Francis Hospital

November 13 — E. St. Louis, Christian Welfare

November 14 — Hinsdale, Hinsdale Sanitarium

November 14 — Alton, Alton Memorial Hospital

November 15 — Rockford, St. Anthony's Hospital

November 15 — Jacksonville, Our Saviour's Hospital

November 16 — Chicago Heights (Rheumatic Fever), St. James Hospital

November 20 — Casey, High School

November 21 — Evergreen Park, Little Company of Mary

November 27 — Peoria, St. Francis Hospital

November 27 — Effingham (Rheumatic Fever), Douglas Township Bldg.

November 27 — E. St. Louis, St. Mary's Hospital

November 28 — Springfield (Cerebral Palsy), Memorial Hospital

November 29 — Bloomington, St. Joseph's Hospital

November 29 — Fairfield, Masonic Temple

ANNUAL DERMATOLOGICAL PRIZE ESSAY CONTEST

The American Dermatological Association is again offering a prize of three hundred dollars for the best essay submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate younger investigators to original work in these fields.

Manuscripts typed in English with double spacing and ample margins as for publication together with illustrations, charts, and tables, all of which must be in *triplicate*, are to be submitted not later than December 1, 1951. The manuscripts should be sent to Dr. Louis A. Brunsting, Secretary, American Dermatological Association, 102-110 Second Avenue, Southwest, Rochester, Minnesota; those which are incomplete in any of the above respects will not be considered.

Competition in this prize contest is open to scientists generally, not necessarily to physicians.

The award will be made by a committee of judges selected to pass on the essays by the Research Aid Committee of the American Dermatological Association and the decision of the judges shall be final. The essays are judged on the following considerations: (1) originality of ideas; (2) potential importance of the work; (3) experimental methods and use of controls; (4) evaluation of results; (5) clarity of presentation; (6) historical background; (7) bibliography. This contest is planned as an annual one, but if in any year, at the discretion of the Committee and judges, no paper worthy of a prize is offered, the award may be omitted.

The prize winning candidate may be invited to present his paper before the annual meeting of the American Dermatological Association with expenses paid in addition to the three hundred dollars prize. Further information regarding this essay contest may be obtained by writing to the secretary of the American Dermatological Association.

The next annual meeting of the American Dermatological Association will be held April 23-26, 1952, at the Broadmoor, Colorado Springs, Colorado.

POLIOMYELITIS DIAGNOSIS

The poliomyelitis experience of 1949 revealed that one of the difficulties of obtaining immediate admission to major polio hospitals centered about the referral of suspect cases. Several areas of the State are at present not covered by medical officers of health who would normally be available for polio consultation. Under these conditions, many suspect cases are transported to larger centers of care without a definite diagnosis and with eventual return of such patients to their homes as not having polio. This is, of course, essentially true for patients exhibiting no evidence of paralysis. Hospital beds have thus been tied up with "non-polios" reducing availability of beds for patients truly requiring care.

To obviate this difficulty it is suggested that spinal punctures be performed on all suspect cases without paralysis before referral of such patients to major polio care centers.

Every effort is being made to encourage all hospitals to provide the minimum service of admitting suspects for such spinal puncture and observation if necessary. The State Polio Planning Committee, through a survey conducted by the Illinois Hospital Association, is stimulating an ever increasing number of hospitals, with otherwise limited facilities, to admit suspect polio cases for diagnostic purposes before referral to major polio care centers.

ORIGINAL ARTICLES



Treatment of Sub-Acute Bacterial Endocarditis With Massive Doses of Procaine Penicillin in Oil

Melvin M. Chertack, M.D., William R. Best, M.D., and Ford K. Hick, M.D.
Chicago

Since it has become evident that large doses of penicillin are effective in the therapy of sub-acute bacterial endocarditis, many schedules of dosage, length of treatment, and supplemental drugs have been proposed. Penicillin doses as great as fifty million units daily have been administered[1,2]. Irons gave up to thirty cubic centimeters of aqueous procaine penicillin twice daily in divided intramuscular injections with therapeutic response and lack of untoward reactions.[3] Several authors report doses up to twenty million units daily.[4, 5, 6, 7, 8, 9, 10]

Investigators generally agree that bacterial sensitivity should be correlated with penicillin blood levels in the management of this condition. It is stated that blood levels should exceed bacterial sensitivity by some arbitrary multiple, usually 4 to 10. In our hands we have failed to control some cases by penicillin levels 10 times the in vitro sensitivity and have found a stepwise increase in penicillin dose also failed because of increasing bacterial resistance. Others have noted similar changes in bacterial sensitivity.[4, 5, 7, 9]

We therefore have followed the plan of heavy dosage initially and continuously over a thirty day period. This often results in ratios of blood level to bacterial sensitivity greatly exceeding those generally considered necessary. Our aim has been to eliminate bacteriologic therapeutic failures and to minimize permanent damage of the valves by this early and vigorous therapy. Criticism of such a regime would consider cost and discomfort primarily. Schlichter et al believe that excessively high doses may actually

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prolong the duration of therapy by reducing the bactericidal rate of the strain involved.[11] Donzelot et al suspected excessive dosage of damaging the myocardium.[2] These assertions are theoretical.

Method of Administration.—We were fortunate in obtaining for these studies a preparation containing 100,000 units crystalline together with 300,000 units procaine penicillin "G" per cubic centimeter in oil.* Two cubic centimeters (800,000 U.) were given intra-muscularly in buttocks and thighs every two hours around the clock for a total of 9,600,000 units daily over a thirty day period. Total dosage was 288,000,000 units or 720 cubic centimeters. Bacterial sensitivities and penicillin blood levels were followed. In some cases carinamide was also administered.

Irons report[3] would indicate that such frequent injections are not neeessary. The prolonged absorption of penicillin from these depots assures a sustained blood level between any conveniently spaced injections. It was our original feeling that smaller and more frequent injeetions would be better tolerated.

CASE REPORTS

Case 1-W.S. This forty-two year old, Negro, male complained of fatigue, headache, fever, pain in the lumbosacral region and night sweats for two months and mild exertional dyspnea for one month. There was no previous history of rheumatic fever, although he had fever of unknown cause at the age of twenty-seven.

On hospitalization, he was moderately ill. The heart was enlarged and a systolic murmur was present at the apex and transmitted over the entire precordium. There was also an early diastolic murmur at the aortic area. His temperature rose daily to 101°-102°F. There were no proven embolic phenomenon on admission. The spleen was not palpable.

The laboratory findings were: occasional red blood cells in the urine, hematocrit of 36, corrected sedimentation rate 32 mm/hour (Wintrobe method), white blood count 9,600, seventy one per cent lymphocytosis. There was moderate left ventricular hypertrophy on the roentgenogram. Positive blood cultures of alpha hemolytic streptococci were obtained on each of three venous blood specimens. The organism was found to be sensitive to penicillin 0.15 units/cc.

Prior to therapy and while diagnosis was being established, the patient developed several periods of acute pain localized in the lumbosacral region and left arm. Microscopic hematuria increased at this time.

Therapy was started as indicated above. He also received carinamide, four grains three times daily for the same period.

The patient became afebrile for the first time, four days after therapy was started and his rectal temperature was normal thereafter. He gained weight and all cultures have been negative since therapy was completed. During therapy, blood levels of penicillin were 10.24 units/cc on the 4th day, 20.48 u/cc on the 19th day, 15.4 u/cc on the 26th day, 20.48 u/cc on the 28th day and four days after treatment was stopped, the blood level was still 0.16 u/cc.

Following therapy, his hematocrit became normal, the sedimentation rate was 7 mm/hour and his wbc was 4,700. He was asymptomatic, felt well, and twelve months after, he is still asymptomatic and quite active.

The patient tolerated the injections of the considerable quantity of oil without difficulty and was allowed bathroom privileges after the second week of therapy. He developed some small subcutaneous nodular areas at site of injections which were slightly tender, but these were not disturbing to the patient and did not interfere with therapy and rapidly disappeared after the cessation of therapy.

Case 2-E.S. This 50 year old white male complained of extreme weakness, dyspnea and hemorrhagic blotches over the lower extremities. He had known of rheumatic heart disease for over thirty years. For 15 years he had had recurrent cardiac decompensation intermittently requiring digitalization and symptomatic therapy. Two years prior to admission, he had been seen at a clinic where a diagnosis of subacute bacterial endocarditis was made on the basis of his underlying cardiac disease, low grade fever and splenomegaly although several blood cultures were negative. He was treated with 0.5 million units of crystalline penicillin daily for 5 weeks. There was little symptomatic relief and there were recurrent episodes of high fever after this therapy.

Physical examination revealed a markedly ill, pale, dyspneic patient with numerous petechiae over the lower extremities. There was evidence of mild cardiac decompensation, cardiomegaly with a harsh systolic murmur heard over the entire precordium. Hepatomegaly was present and a hard nodular enlarged spleen was readily palpable. There was a low grade fever present.

His renal function was decreased and a moderate anemia was present. The sedimentation rate was elevated and after several cultures, an alpha hemolytic streptococcus was isolated from the blood. The organism was sensitive to less than 0.3 u/cc of penicillin and the outlined penicillin regime was begun. Within forty-eight hours, the patient became afebrile, his cardiac status improved, he felt better, ate well and lost much of the edema. Cultures taken were all negative thereafter and within a few days levels of 10.2 to 15.4 u/cc were obtained. After ten days of therapy, levels of 82 and 123 u/cc were obtained; although no carinamide was used. These high levels were partially attributed to the patient's poor renal function. The patient tolerated injections without difficulty.

During therapy the patient complained several times of vague precordial pain, and on the 18th day of treat-

*"Fortified Duracillin" kindly supplied by Dr. J. W. Frost of Eli Lilly & Co., Indianapolis, Indiana.

ment, the patient developed severe chest pain and expired in a few hours.

Postmortem examination revealed old rheumatic endocarditis of aortic and mitral valves, healed subacute bacterial endocarditis, grossly and microscopically, with negative cultures of blood and verrucae, and severe coronary sclerosis and a fresh myocardial infarct were present.

Case 3-V.K. This 33 year old slightly built white female was referred to our institution with a proven diagnosis of subacute bacterial endocarditis for therapy. She first had symptoms four years before admission when she developed exertional dyspnea, fever and tonsillitis. Three years later she again had malaise, weakness, fever, petechiae and convulsions. Eight months before admission a diagnosis of subacute bacterial endocarditis was made without positive blood culture and treatment with 400,000 units of penicillin daily was given for two weeks. She had some slight symptomatic improvement only to have a recurrence of chills and fever, petechiae and splenomegaly prior to admission. Alpha hemolytic streptococci were isolated from the blood elsewhere and again here.

She was a markedly pale, febrile, actutely ill patient. The above history as well as that of questionable chorea and recurrent tonsillitis in childhood were elicited.

Several conjunctival petechiae were present as was a grade II systolic murmur and a palpable spleen. The renal function was good. The organism was sensitive to between .039 and 0.078 u/cc of penicillin.

On the above outlined penicillin regime, she became afebrile by the sixth day of therapy and remained so. Blood cultures were negative within 24 hours. Blood levels of 15 to 30 u/cc were obtained and five days after therapy was stopped the level was 1.9 u/cc.

Up to the present time she has been asymptomatic for 10 months carrying on duties of a housewife without difficulty. She tolerated the injections with no complaints and was able to have bathroom privileges during most of her stay.

Case 4-G.H. This 37 year old white housewife was transferred from another hospital with a diagnosis of subacute bacterial endocarditis. She had suffered from cyanosis, retarded development, recurrent syncope, and exertional dyspnea since birth. Several previous hospitalization here and elsewhere had established a diagnosis of Tetralogy of Fallot by fluoroscopy and cardiac catheterizations. The possibility of concomitant patent ductus arteriosus was considered but never proven. On prior admissions opinion was divided regarding the advisability of a Blalock type of operation. In the fifteen years preceding admission she had tolerated several major operations without incident. She was subject to repeated bouts of pneumonia, and had developed a marked generalized urticaria after six days of penicillin treatment several months earlier. This had responded to pyrabenzamine, drying lotions, and cessation of penicillin.

Several weeks prior to admission at the other hospital she experienced a severe sore throat associated with dysuria, frequency, and urgency. Chills, sweats, malaise, joint and muscle pains, and fever followed this initial episode.

Physical findings included general underdevelopment, cyanosis, clubbing of the digits, cardiac enlargement, continuous murmur with systolic accentuation in the pulmonic area and widely transmitted, and tenderness over the right kidney. Daily elevations of temperature varied from 99 to 102°F. No petechiae were seen, nor was her spleen palpable, but left upper quadrant tenderness was noted.

Laboratory studies revealed 1+ albuminuria, hematocrit of 60%, Wintrobe sedimentation rate of 7 mm/hr., and electrocardiogram showing a right heart strain pattern. Blood cultures were positive for α-streptococci (penicillin sensitivity was 0.08 units/cc).

Treatment with massive doses of penicillin was initiated as outlined above. Within eighteen hours temperature was normal and remained at about 97.8°F. for the following week. On the seventh day of therapy giant urticarial wheals appeared on her body. Pyrabenzamine and drying lotions effectively controlled these symptoms, and they did not bother her throughout the remainder of treatment. Afternoon temperatures were elevated to about 100°F. following this reaction until the end of therapy when they returned to normal. Penicillin levels as high as 41.9 u/cc were obtained, and a blood level of 2.56 u/cc. was demonstrated two days after all penicillin had been stopped. Despite the fact that she was quite thin, this patient tolerated injections well and was ambulatory through much of the treatment period. Non-tender areas of induration and fluctuation up to a few centimeters in diameter appeared occasionally at sites of frequent injections. These regressed spontaneously when injections sites were rotated elsewhere. At time of discharge and on subsequent check-ups during the succeeding ten months she felt better than she had for many months preceding admission and repeated blood cultures remained negative. She died immediately after attempted surgery for congenital heart disease ten months after the admission reported. There was no evidence for active endocarditis at necropsy.

Case 5-S.K. This 15 year old white school girl had rheumatic fever with migratory polyarthritis and chorea at age eight. After prolonged bed-rest she was gradually allowed increasing activity until she engaged in most sports without difficulty. One month prior to admission she suffered an episode of headache with fever to 104°F. This was treated by penicillin with temporary improvement. Two weeks later she complained of pain in the left hip and later in other joints without obvious swelling or redness. There was associated fever and weakness.

Physical examination on admission revealed a moderately obese girl with minimal pallor and malar flush, slight cardiac enlargement, harsh apical systolic murmur and thrill. The murmur was transmitted over the entire precordium and into the axilla. There was pain on movement of hips and back but no obvious joint swelling or tenderness. No petechiae were noted and the spleen was not palpable.

Laboratory studies showed Wintrobe sedimentation rate was 29.5 mm/hr., right ventricular and left auricular enlargement on fluoroscopy, and blood cultures were positive for α-streptococci (penicillin sensitivity was 0.01 u/cc.).

Prior to return of positive blood cultures she was considered to have an acute exacerbation of rheumatic fever and was consequently treated by bed-rest and salicylates. Temperature remained elevated at 101-102°F. One week after admission the spleen became palpable. Several days later one petechia was noted on her conjunctiva.

Massive penicillin therapy as outlined was then initiated. Within 36 hours she was afebrile; temperature remained normal for nine days. On the ninth day she developed induration, itching, and redness at the sites of previous injections in the buttocks. The following day joints pain was noted in the left wrist with a macular eruption about that joint. Mean temperatures rose approximately one degree. She was placed on pyrabenzamine and injection sites were rotated. The local reactions disappeared and she was able to tolerate the remainder of therapy without incident. The spleen remained palpable but not tender throughout the course of treatment. New petechiae were seen on several occasions during the first two weeks of treatment. Penicillin blood levels of 10 u/cc. were obtained without additional carinamide and of 20 u/cc. with it. Blood levels of 10, 2.5, and detectable but less than 1 unit/cc. were obtained 2, 5, and 7 days after penicillin was stopped. Clinical condition was markedly improved and blood cultures have remained negative during the succeeding four months. Spleen is no longer palpable.

Discussion.—In each of these cases we have produced a bacteriologic cure, and in all but the man with intercurrent myocardial infarction a clinical cure of the infection. Blood levels as high as 123 U./cc and representing up to 2,000 times the sensitivity of the organism have been demonstrated on this regime. In two cases early allergic reactions to the preparation did not preclude continuation of massive penicillin doses over the thirty day period. In no case was local reaction to injections bothersome enough to warrant cessation of therapy. Carinamide again was demonstrated to be of value in elevating penicillin blood levels during a given therapeutic regime. Patients were not restricted to bed rest by continuous intra-venous or intra-muscular drips.

Selection of a dosage schedule for sub-acute bacterial endocarditis is difficult and will perhaps always remain somewhat arbitrary. We are not presenting our schedule as a final answer to the optimal management of this condition, but rather as an interesting observation regarding tolerance of patients to these large doses of penicillin in oil and illustrating the satisfactory therapeutic response to such a regime in a small series of cases with minimum demands upon hospital personnel.

Since these cases were collected, we have treated two additional such patients with equal daily doses of aqueous procaine penicillin given in larger individual doses at less frequent intervals, and have observed similar satisfactory results.

The man (Case 2) who died of acute myocardial infarction on the eighteenth day of massive penicillin treatment showed healed endocarditis at necropsy. Various observers differ as to the minimal effective duration of treatment. At least six weeks of therapy are favored by many. King et al compare the effects of prolonged moderate dosage to intensive two week therapy and recommend the former.[12] Healing of lesions in a single case proves nothing about the safety of short courses as a general policy. It seems best to err on the side of excessive therapy.

CONCLUSIONS

(1) Patients tolerated 9,600,000 units of crystalline and procaine penicillin in oil by intermittent intra-muscular injection daily for thirty days.

(2) This schedule is simple and easy to administer.

(3) This schedule has apparently produced clinical cure in the five cases studied. One patient died of other causes, but was bacteriologically cured. In all cases the organisms were relatively sensitive to penicillin.

(4) Side reactions were easily controlled and resulted in no lasting symptoms in these cases.

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Office Psychiatry

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Office psychiatry is what every physican whether in general or special field practices every day as he or she sees patients coming into the office. There is no special technique involved in most situations. A doctor would not be a doctor if not interested in people. The recent upsurge in so-called psychosomatic medicine is nothing more than a restatement of interest in people who have illnesses rather than in the illnesses themselves. Whether one approaches this from the semi-objective standpoint of Weiss and English,[1] the descriptive angle of Dunbar[2] or the psychoanalytic views of Alexander[3] the underlying philosophy is essentially the same. The recent publication of Stanley Cobb, "Emotions and Clinical Medicine"[4] summarizes a type of thinking that means much to all of us. It may be that because of previous association some years ago with Dr. Cobb's instruction and because of his neurophysiological approach that his ideas have this appeal to the writer. However, along with this come some clinical observations over the years that bring comforting reassurance from the Ranson school of neuroanatomy and neurophysiology.

Office psychiatry means quite definitely in the writer's opinion the help that can be offered to those people whose illnesses do not require hospitalization, or the special "work ups" that seem to be a factor in some clinics. It is important to be sure that underlying organic pathological conditions be ruled out. We must all remember the statement of Dr. Frank Billings of Chicago, one of the great clinicians of the preceding generation, that 85 per cent of illnesses coming under the purview of the physician can be diagnosed on history and physical examination. Along with this can be applied McLean's report[5] that of out-patients coming to the medical clinics of the University of Chicago 40 per cent had definite functional disorders, another 40 per cent had concomitant functional and organic conditions, leaving 20 per cent with definite organic pathological conditions. Therefore, it can be fairly categorically stated that 80 to 85 per cent of most patients coming to the office of the general practitioner or the internist have functional disorders or associated symptoms and signs.

Those of us interested in neuropsychiatry are much more interested in the people outside of hospitals than those within. The latter group represent individuals who have either lost contact with reality or whose reactions to their own environment are such as to make it inadvisable for them to remain in the home. This may appear rather inconsistent as a statement from a person connected with a hospital. Yet from the broad mental hygiene aspect it is a considered positive opinion. The aim of any hospital staff of any type is to return the patient to the home situation as rapidly as possible. The aim of any office, clinic or out-patient service is to keep

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the patient out of the hospital, to maintain circulation and contact with the environment, to keep him or her on the job. This is more applicable than ever at this time in our country's history.

While some or much of this may sound theoretical it has practical import for all of us physicians. When the figures given above are considered, certain situations face us when a patient comes into the office.

If any one factor is to be considered it is the element of time. Recognizing fully that the busy physician is hard pressed for time the clinical history probably means more than anything else. From the psychiatric standpoint this statement can well be made, that after all the most important person in the world to anyone of us is the person himself or herself. Then there are three other things that affect the person towards people and things round about. These are tied in with the instincts or drives that dominate us all. They are (1) that of self preservation, (2) that of race preservation which means the sexual field in the broad sense, (3) that of social or communal relations. If the story the patient gives indicates some disturbance in one or more of these and if no definite physical cause is found for the symptoms described then office psychiatry is definitely indicated.

Office psychiatry is much more than prescribing bromides, barbiturates or injections of members of the B complex, the "nerve vitamins." It is an understanding of the family, social and business background of the patient which you in general practice have and which the man in special fields cannot find out without a lot of inquiry. It is something to be carried out in a positive manner in an effort to explain to Mr. A. that his nausea and vomiting is a rejection of a situation that he cannot accept because his ego won't let him. It is telling Mrs. B. that her urinary frequency or dysuria, after organic conditions are ruled out, are due to marital infelicity. It is telling Johnny Jones and his parents that Johnny's enuresis is due to the fact that Johnny thinks the parents are paying more attention to little brother Willy than Johnny thinks they should. It is showing Mr. or Mrs. C. that their escape from facing life by taking too much alcohol is due to an immature approach and failure to adopt a grown up mature attitude in keeping with responsibilities they have accepted in other phases.

The whole approach should be positive. The military adage of a courageous offense being the best defense most certainly applies in conditions indicated above and in many others. It is believed that it is basic that a positive approach is necessary and that it is a grave mistake to take a negative attitude or to allow one's self to be put on the defensive. This is even more applicable when the emotional or feeling side of consciousness is involved. After all the emotional side or how we feel about people or things influences us more in our daily life than the intellectual side or what we know. It is important to communicate this to our patients and make them realize that we can help them to adapt to things as they are and can explain to them some of their translations of their concern to bodily symptoms.

Certain positive precepts are applicable in these explanations. The Illinois Society for Mental Hygiene put out a set of these some years ago. They cover most situations that come up in discussion of symptoms that most patients with functional disorders present. One or more of them have been found useful in presenting in epigrammatic style something with which the patient may tie in his or her problem. Therefore, it is felt worth while to offer them here. Reinforcement in greater detail is easily added for the particular problem of the patient at the time and bears reiteration at subsequent visits.

They are:

Pay Attention: Ability to think of the present task results in mental efficiency.

Cultivate Courage: Timidity, fearfulness, lack of self-confidence indicate need of mental hygiene.

Seek Self-control: Not by repression of hate, fear, anger, love and other emotions but diversion of these emotions into other channels through wholesome activity.

Live In The World Of People: Avoidance of others, inability to adapt to groups, lack of thought for others prevents the cultivation of mental hygiene.

Develop Serenity: Confusion in work, play and study, conflict of ambitions with achievements, conflict of thoughts and feelings lead to lack of mental health.

Roll Your Own: Ready made toys, ready

made music, ready made thoughts prevent the cultivation of mental hygiene.

Use Your Mind: The exercise of the mind is as important to mental hygiene as physical exercise is to physical hygiene.

Live Life: Escaping from unpleasant situations through evading them, building up defenses, avoiding life is poor mental hygiene.

Keep Well: Mental health is related to physical health.

Train Your Child Early: Tantrums, jealousy, whining, finicky eating, irregular sleeping, lack of toilet habits, over-dependence indicate need of mental hygiene.

An attempt has been made to outline an approach in office psychiatry which all physicians can carry out. It is hoped it will be of help to the most important person, the patient, who entrusts his or her life with its problems and its fears to us.

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The Use of Anticoagulant Therapy in Medicine

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Anticoagulant therapy in internal medicine is of value in treating venous thrombosis with or without secondary pulmonary embolism, arterial thrombosis, and arterial occlusion by emboli.

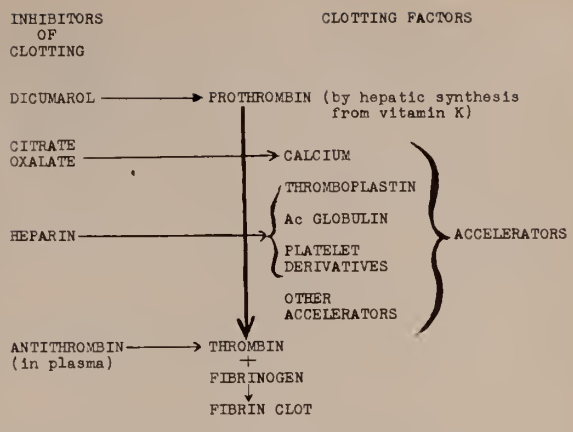
Venous thrombosis in the legs and pelvis occurs with equal frequency in medical and surgical patients. Compilations by Zilliacus[1] and Wright[2] show venous thrombosis complicating 0.95% to 3.5% of operative cases, and 1.3% to 2.9% of non-operative illnesses. These two studies show, among 4,445 cases of venous thrombosis in post-operative patients, a 54% incidence of pulmonary embolism, one-third of which were fatal. In medical patients the incidence of pulmonary embolism probably is the same. Fatality from pulmonary embolism is greater among medical patients because they are usually in poorer condition. It is necessary, therefore, to examine medical patients, as well as post-operative patients, daily for the following signs of peripheral venous thrombosis: pain and tenderness of the calf muscles or over Hunter's canal, swelling with color and temperature change of the leg, dilatation of the superficial pedal veins, and unexplained increases in pulse, temperature, and malaise. If evidence of venous thrombosis is found, anticoagulant therapy should be instituted promptly. Zilliacus[1] has shown that heparin therapy will reduce the spread of thrombosis from calf to thigh from a frequency of 88% to 10%. The days of fever drop from an average of 23 to 8. Serious late edema and ulceration are reduced from an incidence of 60 to 80% to nullity. Allen *et al*[3] record a reduction of pulmonary embolism from 25.3% to 2.8%, and a reduction of fatal embolism from 18.3% to 0.3%.

Arterial thrombosis may occur in the lumen of any diseased artery, and most commonly af-

fects the coronary, cerebral, and femoral arteries. The use of anticoagulants in cerebral artery thrombosis is questionable because frequently it is difficult to distinguish cerebral thrombosis from hemorrhage. Allen *et al*[3] report saving 13 out of 16 limbs suffering arterial thrombosis when anticoagulants were used in the first 24 hours. When treatment was started after 24 hours, 5 out of 10 limbs were saved. The value of anticoagulant therapy in coronary artery thrombosis appears to be established. Wright *et al*[4] report a reduction in death following coronary artery thrombosis from 24% to 15%. Deaths associated with pulmonary embolism from venous thrombosis, and from peripheral arterial emboli thrown from the heart, were reduced from 10% to 3%. Deaths not associated with thromboembolism were reduced from 14% to 12%. It is apparent that the chief value of anticoagulant therapy in coronary artery thrombosis lies in the prevention of thromboembolism. Thromboembolic complications, both fatal and non-fatal, were reduced from an incidence of 25% to 6%. During the period of anticoagulant therapy, infarction of new areas of myocardium was reduced from 6.5% to 2.5%, and extension of the original infarction from 9% to 2%. Long-term use of dicumarol, in an attempt to forestall recurrent coronary artery thrombosis, is under study[5].

Arterial embolism results when thrombi are released into the arterial circulation from diseased and dilated heart chambers, especially following myocardial infarction and in chronic rheumatic heart disease. Anticoagulant therapy reduces the incidence of such clot formation and release following acute myocardial infarction[4]. Long-term dicumarol therapy has been of striking value in preventing recurrent embolization in patients with chronic rheumatic heart disease[2]. Once embolization has occurred, Allen *et al*[3] saved 10 of 11 limbs when heparin therapy was started within 24 hours, but only 2 of 8 limbs recovered when treatment was delayed beyond 24 hours.

Anticoagulant therapy is of established value. The abuses and accidents of such therapy stem principally from the failure to appreciate the various factors concerned in blood clotting, and the significance of the tests used in studying the anticoagulant effects of heparin and dicumarol. Figure 1, adapted from Seegers[6], is a



After Seegers, W. H.: Circulation 1: 2, 1950.

Figure 1.

schematic presentation of the present concept of coagulation and the action of the anticoagulant drugs. Prothrombin, formed by hepatic synthesis, slowly is converted to thrombin. Thrombin acts upon plasma fibrinogen to produce the fibrin clot. However, the rate of conversion of prothrombin to thrombin is so slow as to be physiologically useless unless certain accelerator factors are present. The most important recognized accelerator factors are ionized calcium, thromboplastin released from tissues, accelerator globulin formed by the liver, and blood platelet derivatives. For normally rapid clotting, the accelerator factors and prothrombin must be present in optimally balanced quantities. It is understandable that a patient may have the quantity of prothrombin reduced to a level bordering on hemorrhage (5% to 10% of normal) and yet not bleed if optimal concentrations of accelerator factors convert the small amount of prothrombin to thrombin swiftly and efficiently. Conversely, hemorrhage may occur at "safe" levels of prothrombin (20% of normal) if proper and prompt conversion to thrombin fails because of insufficient or unbalanced accelerator factors.

Two tests are used for determining the prothrombin content of the plasma: the "one-stage" test of Quick[7] and the "two-stage" test of Warner, Brinkhous, and Smith[8]. The one-stage prothrombin clotting time (PCT) is a measurement of the clotting time of oxalated plasma after the addition of optimal calcium chloride and an excess of thromboplastin. The defect of this test is that the PCT is influenced not only

by the amount of prothrombin present, but also by the various accelerator factors and the concentration of fibrinogen. Though this is a defect as a true measurement of prothrombin concentration, it is an advantage in that it is a good test for the total activity of all factors involved in clotting and is a good indicator of impending hemorrhage. The two-stage PCT eliminates the accelerator and fibrinogen factors by dilution, and is a better measurement of prothrombin content. Conversely, by eliminating these other factors, it is inferior to the one-stage test as a detector of impending hemorrhage (Olwin, [9,10]). It is to be emphasized that prothrombin clotting time and prothrombin content of the plasma are not directly proportional. If the PCT is 15 seconds for a normal plasma concentration of prothrombin, a PCT of 30 seconds will represent approximately 20% normal plasma concentration of prothrombin. If the PCT is prolonged to 45 seconds, it will represent about 10% of normal prothrombin. Thus a doubling of the PCT represents a reduction of prothrombin to about one-fifth of normal, and a tripling of the PCT represents a reduction of prothrombin to about one-tenth of normal. Either the one-stage or the two-stage test may be used for controlling dicumarol therapy, keeping in mind the limitations and advantages of each test. For testing the anticoagulant effect of heparin, the clotting time of whole blood in a small test-tube by the Lee-White technique is usually used. The one-stage PCT technique of Quick is also a good index of heparin activity[9].

Effective anticoagulant therapy can be achieved with either heparin or dicumarol. Each has its advantages and disadvantages. Heparin, given intravenously in 50 mg amounts every 4 hours day and night[3], or in 75 to 125 mg. amounts 4 times daily[1], rarely results in bleeding if thrombophlebitis is present, and is adequate clinically. If bleeding were to occur, protamine (salmine sulfate) given slowly intravenously, in the same milligram dose as the last dose of heparin, will return the clotting time to normal within 5 minutes[11]. When heparin is given in 50 mg. doses intravenously every 4 hours, the performance of clotting times is preferable but not essential. The method of constant intravenous drip, with 200 mg. heparin diluted in 1000cc of physiological saline solution given at rates of 1.5 to 2.0 cc per minute, requires clotting time determinations every 8 to 12 hours. The clotting time should be maintained at about 3 times the control value: prolongation from a normal of 5 to 10 minutes to a therapeutic level of 20 to 30 minutes. Both the intermittent and constant intravenous methods are relatively safe, heparin effect is easily overcome, the technical difficulties of administration are small, and the laboratory control of the clotting time is relatively easily performed. The disadvantages are the cost of heparin, about $24 for 24 hours, and the discomfort of intravenous administration if treatment is to be used for weeks or months. The use of 10% heparin in water, intramuscularly in 100 milligram amounts every 8 hours, or 120 to 140 mg. every 12 hours, has been successful[12]. Heparin suspended in Pitkin's menstruum[13], wax and oil[14], or in gelatin and dextrose [15] may be given intramuscularly in 200 to 300 mg. amounts every 24 to 48 hours. The "depot" methods have the advantages of less frequent administration and lower cost, and the disadvantage of erratic effect upon clotting time, requiring careful performance of clotting time at least every 12 hours. The immediate effectiveness of intravenous heparin, and the promptness with which it can be neutralized, make it the drug of choice in all acute thromboembolic emergencies.

Dicumarol is the anticoagulant of choice for long periods of therapy. It is given once daily, orally, and is inexpensive. The cost of the prothrombin determination is about $3.00. The prothrombin determinations must be done accurately and must be performed daily before each dose of dicumarol is given. As has been emphasized, the prothrombin clotting time determination cannot be an absolute gauge of the tendency to bleed. If bleeding does occur, blood transfusion is the most prompt antidote. James *et al*[16] have shown that "Hykinone" in 64 to 180 mg. amounts, and "Synkayvite", in 100 to 500 mg. amounts, given intravenously, will raise the prothrombin to above the bleeding level within 9 to 14 hours. Vitamin K-1 oxide, 100 to 500 mg. intravenously, will accomplish this end within 4 hours. Remembering that heparin and dicumarol are synergistic, heparin may be given simultaneously with the first doses of dicumarol so that one has the advantage of the immediate effectiveness of heparin while awaiting the delayed action of the dicumarol. The

heparin is discontinued when, after 1 to 3 days, the dicumarol becomes effective.

Anticoagulant therapy should be used not at all, or only with great care, in the presence of hepatic insufficiency with the frequent association of prothrombin deficiency. Renal insufficiency and sepsis are accompanied by hemorrhagic tendencies and an erratic response to anticoagulants. In blood dyscrasias and peptic ulcer hemorrhage may be precipitated by the anticoagulants. These contraindications emphasize the many factors involved in thrombosis and in hemorrhage, the need for accurate laboratory studies, and the importance of a thorough knowledge of the patient's general physical and physiological status.

SUMMARY

The anticoagulants, heparin and dicumarol, are of established value in the treatment of abnormal thrombosis and the resultant thromboembolic occlusion of veins and arteries.

Tests of clotting time for whole blood and for prothrombin must be performed accurately and be interpreted physiologically, and not be mistaken for a literal prophecy of the hemorrhagic tendency in the sick patient.

Heparin therapy is immediate in action and is more simply and safely controlled than is dicumarol. Both substances, however, must be used with care and control, and antidotal blood transfusion and drug therapy must be at hand.

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BITES AND STINGS

The three most common bites are those of the dog, snake, and black-widow spider. Since there is no treatment for rabies, prevention is all that can be offered. Two main types of vaccines are available. In the treatment of snake bites, the successful use of antivenin depends on the time of administration and the dosage. Calcium gluconate or lactate serves as a diagnostic, as well as therapeutic, measure for spider bites. Calcium is valuable therapy for insect, scorpion, and stingaree stings. *Excerpt: Bites and Stings, D. G. Miller, Jr., M.D., Morgantown, Ky., GP, July, 1951.*

Lansing Poliomyelitis Virus Neutralizing Antibody Titers of Different Types of Human Serum*

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Divergent opinions[1] of the value of specific "convalescent" serum in the treatment of acute poliomyelitis may be correlated with variations in potency of the serum employed. The use of the mouse-adapted Lansing strain of poliomyelitis virus, together with a better understanding[2] of the quantitative aspects of neutralizing antibody titrations, makes it possible to assay more accurately poliomyelitis convalescent serum and determine the conditions under which maximum potency might be anticipated.

From immunologic considerations of disease in general, it is known that serum antibody levels will vary greatly in recovered individuals dependent in part on the dose and nature of antigen (form and severity of the illness), and the time elapsed since onset. Furthermore, the level is usually highest early in convalescence and falls off more or less rapidly with passage of time. The term "convalescent serum" in scarlet fever, measles, etc., has been reserved for serum obtained from individuals no longer than six months after recovery. In contrast to this, serum obtained from a person recovered from poliomyelitis has been called " convalescent serum" with total disregard to the interval between the acute illness and the time the serum was collected. The term "convalescent serum" implies serum of greatest potency. However, if the antibody levels fall with passage of time in poliomyelitis as they do in other diseases, then, obviously, the designation "convalescent" should be limited. Every therapeutic serum should be proved to be of satisfactory potency by laboratory assay or, if this is presently impossible, should be obtained from donors most likely to yield maximum-potency serum. The actual standards must be determined separately for each disease. Such standards for poliomyelitis convalescent serum have not been previously established. In the absence of standards, low-potency, therapeutically ineffective serum might be employed.

This study was carried out to compare the relative potencies of serum obtained from human donors two, five, ten, and twenty years after an acute attack of non-paralytic, bulbar, or spinal paralytic type of poliomyelitis. A non-paralytic diagnosis was made in patients with an acute febrile illness with onset in the poliomyelitis season accompanied by signs and symptoms of meningeal irritation, characteristic changes in the spinal fluid but no paralysis. Diagnosis was established in bulbar and spinal cases by characteristic paralysis; in most instances spinal puncture was done, and the spinal fluid showed characteristic changes. Clinically questionable cases were excluded from the study.

Methods. Blood taken from each donor was allowed to clot spontaneously and centrifuged at 2000 r.p.m.; the serum was then drawn off and stored in the frozen state at -76°C. until used. Each neutralizing antibody titration was performed on a pool composed of equal amounts of serum from ten individuals. Mice (CFW Swiss, five to six weeks old) were inoculated intracerebrally with 0.03 cc. of a mixture of equal amounts of ten-percent centrifuged mouse brain Lansing virus suspension plus the pooled convalescent serum diluted as indicated in Table 1. Controls received normal mouse serum plus virus, simultaneously. The technique of the neutralization test employed and the preparation of stock virus suspension from the pooled brains and cords of mice paralyzed two to five days after inoculation

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TABLE 1

Titration of Lansing Poliomyelitis Virus Neutralizing Antibodies in Human Serum

Type of Serum	Average Years After Acute Attack	Average Age at Time of Illness	Serum Dilution 1:10	1:50	1:100	1:250	1:500	1:1000	Approximate "50% End-Point"
Nonparalytic	2.1	12.1	3/8*	4/8	7/8	8/8			1/50
Nonparalytic	5.4	15.0	3/8	6/8	8/8	8/8			1/20
Nonparalytic	10.1	6.9	4/8	5/8	7/8	8/8			1/20
Controls**	—	—	8/8		8/8			8/8	
Gamma Globulin	—	—		0/8	0/8	4/8	6/8		1/250
Bulbar Paralytic	2.1	11.8	0/8	2/8	4/8	6/8			1/100
Bulbar Paralytic	5.1	12.7	1/8	4/8	4/8	7/8			1/75
Bulbar Paralytic	9.7	9.3	5/8	4/8	7/8	8/8			1/20
Controls	—	—	8/8		8/8			8/8	
Gamma Globulin	—	—		0/8	1/8	4/8	8/8		1/250
Pooled Adult Lot 319	—	—	4/8	4/8	7/8	8/8			1/30
Spinal Paralytic	1.9	14.2	0/8	1/8	4/8	4/8			1/175
Spinal Paralytic	5.2	17.2	0/8	0/8	3/8	4/8			1/160
Spinal Paralytic	9.4	9.6	4/8	5/8	7/7	8/8			1/20
Spinal Paralytic	21.1	6.0	2/8	5/8	8/8	8/8			1/30
Controls	—	—	8/8		8/8			8/8	
Gamma Globulin	—	—	0/8	0/8	1/8	3/8			1/250†
Pooled Adult Lot 300	—	—	3/8	5/8	8/8	8/8			1/25

*Numerator—No. of animals which developed paralysis and died. Denominator—No. of animals inoculated.
**Normal mouse serum.

are described in a previous publication[3]. Equal parts of whole serum (0.3 cc.) and ten-per-cent virus pool were thoroughly mixed and allowed to stand at room temperature for one hour. Each serum-virus mixture was then inoculated intracerebrally into each of eight mice, and the animals were observed for thirty days. Tests were also carried out on two pools (eighteen donors per pool) of human serum derived from normal urban adults and on one lot of commercial concentrated human immune globulin (gamma globulin) prepared from normal human plasma by the methods of Cohn.

Results. The approximate LD_{50} titer represents an accepted means[4] of comparing serum-antibody titers (Table 1). The normal human serum controls show LD_{50} titers of 1:30 and 1:25, respectively, representing the level of neutralizing antibodies against the Lansing strain of virus in normal human adult serum. All serums tested from non-paralytic cases showed 50% end-points in the same range of 1:20 to 1:30, obviously, these serums are no better than normal human serum. Serum obtained from bulbar cases two years after the attack shows an LD_{50} titer of 1:100, and five years later, 1:75. However, serum obtained ten years after illness shows an LD_{50} titer of 1:20, i.e., it is within the range for normal human serum. Highest potencies are found in serum obtained from individuals with spinal type of paralysis: at two years, the titer is 1:175 and at five years after the illness, 1:160. The titers of 1:20 and 1:30 after ten and twenty years, respectively, fall within the normal human serum range. The gamma globulin shows a titer of 1:250, which is roughly ten times the titer of normal human serum and in accord with the estimates of ten-fold concentration of antibodies generally claimed for the fractionation methods of Cohn.

Discussion. The surprisingly low titer found in nonparalytic cases may be explained in several ways. The diagnosis being presumptive, it is possible that some of the patients were not really cases of poliomyelitis. It is also possible that administration of convalescent serum to all of these cases during the acute illness may have interfered with antibody production. Finally, since this form of the disease is much milder, stimulus to antibody production may have been weaker than that which occurs in the more severe bulbar or spinal paralytic infection. In any event, it seems clear that serum from such donors is no richer in virus-neutralizing substances than normal human serum and should not be used as poliomyelitis convalescent serum.

Serums from bulbar and spinal paralytic cases appear to be most potent if collected in the period from two to five years after the attack. Future studies are planned to investigate the period from acute attack to two years after, and from five to ten years after as well. The titers obtained in this study suggest that the period up to five years after onset of illness is to be preferred for serum collection.

The finding of high antibody titers in gamma globulin has been previously reported by others[5,6]. Bodian[7] has recently shown that antibodies against all 3 known antigenic types of poliomyelitis virus exist in high concentration in gamma globulin. Although Bahlke and Perkins[6] found that relatively large amounts of gamma globulin prepared from normal adult serum were ineffective in the therapy of preparalytic poliomyelitis, we feel that this fraction prepared from potent convalescent serum might be effective. On the other hand, gamma globulin from normal adult serum may be of value in prophylaxis of exposed individuals if contact has been intimate. Perhaps a dose of 20 cc. intramuscularly would be adequate.

The range of titers shown by these various types of "convalescent" serum might easily explain the variable results reported with the use of "convalescent serum" in therapy of poliomyelitis. In practice, poliomyelitis "convalescent serum" is obtained from individuals stated to have suffered an attack of poliomyelitis. Adults are the principal blood donors, and most of them have contracted the disease in childhood or infancy. Patients who escaped paralysis are usually glad to serve as donors. Many are willing to give blood year after year. In the absence of strict qualifications, a very large proportion of the serum obtained is likely to be relatively low in potency and no better than normal human serum. Insistence upon the qualifications suggested by our data means that many of the most willing donors will not be eligible, either because the five-year limit is exceeded or because there is no evidence of paralysis. These qualifications are, nevertheless, justified to insure serum of maximum potency.

Another advantage of restricting the time period during which donors may serve is the exclusion of cases with onset in infancy. In the past, almost any paralysis occurring in infancy was likely to be called "infantile paralysis." Since the disease is unusual in the first year of life, cases with onset in infancy are best disqualified as donors for convalescent serum.

Summary and Conclusions. 1. There is considerable variation in potency of Lansing neutralizing antibody titers of poliomyelitis "convalescent" serum, depending upon the type of poliomyelitis suffered by the donor and the time elapsed since the attack.

2. The most potent serum with highest titer of Lansing neutralizing antibodies is obtained from donors who suffered an attack of poliomyelitis with spinal type of paralysis; the next is obtained from donors who suffered an attack of poliomyelitis with bulbar type of paralysis. Donors with nonparalytic poliomyelitis given serum low in titer and if serum is used should not serve as donors for "poliomyelitis convalescent serum."

3. The optimum period for blood donations is in the five years following the attack. No donor should serve after ten years.

4. Gamma globulin prepared from normal human plasma shows a relatively high titer and might be of value for protection of intimately exposed contacts.

5. The variable results reported with the use of "convalescent serum" in the therapy of poliomyelitis may be due to variations in the titer of virus neutralizing antibodies of the administered materials.

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Trends in the Management of Appendicitis in Children

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That the management of appendicitis in children has improved in the past few years is evident from the decrease in mortality.

In 1938, Potts[4] published the results of a study of patients with appendicitis which included all cases treated at the Children's Memorial Hospital from 1921 to 1935. A total of 592 children with appendicitis were admitted to the hospital during this period. Of these children, 297 had acute and gangrenous appendicitis and the mortality rate was 1 per cent (3 deaths). There were 190 patients with perforated appendices and peritonitis with a 16.3 per cent mortality rate (31 deaths). Thirty-two patients with conservatively treated appendiceal abscesses had no mortality and 73 patients with surgically treated appendiceal abscesses showed a mortality rate of 5.4 per cent (4 deaths). It should be noted that in the group with perforated appendices and diffuse peritonitis there was a decrease in mortality from 21.6 per cent to 12.1 per cent in the last five year period (1931-1935) of this study. This reduction was attributed to the use of adequate parenteral fluids and intestinal intubation for decompression.

The present series, which will be used for comparison, includes all patients with appendicitis admitted during the four year period from January 1, 1946 to January 1, 1950. During this period, the sulfonamide drugs, penicillin and streptomycin, were available. A total of 178 cases was treated. Of this number, 110 patients had acute and gangrenous appendicitis and 68 had perforation of the appendix. These two groups will be considered separately.

Acute and Gangrenous Appendicitis. Of the 110 patients with acute and gangrenous appendicitis, all showed evidence of acute inflammatory changes on both gross and microscopic examinations. There was no mortality in this group. No serious problems in management were encountered. The operations were performed under general anesthesia (usually ether) through a muscle-splitting incision. The appendiceal stump was ligated and usually turned in with a purse-string suture of silk. If contamination of the abdominal wall was likely, a small, soft, rubber drain was placed in the wound to the peritoneum. In cases where toxic manifestations were evident, sulfadiazine, penicillin and streptomycin, either singly or in various combinations, were used.

The complications were not serious. One patient, because of postoperative bleeding from a small subcutaneous artery, required opening of the wound and ligation of the bleeding point. Several patients had superficial abscesses which healed promptly after adequate drainage.

Appendicitis with Perforation. In this division, there were 68 patients with 3 deaths, a mortality rate of 4.4 per cent. Fifty-three patients had diffuse peritonitis and in 15 patients, abscess formation followed perforation. The high incidence of perforation (38 per cent of the entire series) may be the result of several differences between children and adults. In children, a large amount of lymphoid tissue in the appendix may allow easier and earlier perforation. The omentum is short and poorly developed so that it is unable to wall off a spreading appendiceal infection as readily as in later life. Appendicitis is not recognized as easily in infants and very young children because they cannot talk and describe their symptoms. In addition, the evaluation of physical findings is difficult. In older children with perforation, these factors are usually not as responsible as delay in diagnosis. The average age of the patients in whom perforation occurred was 5.9 years. (The maximum age for admission to this hospital is 12 years.)

I — PATIENTS WITH PERFORATION AND DIFFUSE PERITONITIS

The only deaths which occurred in the entire series were in patients with diffuse peritonitis following appendiceal perforation. Abstracts of

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the records of the 3 fatal cases, in the 53 patients with diffuse peritonitis, are worth considering.

Case 1. — A white male, 3 years of age, entered the hospital on 1-1-46 and expired on 1-3-46. Five weeks before admission, he was treated for an upper respiratory tract infection with a purulent otitis media. He never seemed to completely recover from this illness. Two weeks before admission, he began to vomit but did not complain of pain. The vomiting continued about once a day until four days before admission when diarrhea began. During this time, his condition became progressively worse. Two days before admission, he was taken to another hospital but no improvement occurred. He was then transferred to this hospital and was extremely ill, with signs of diffuse peritonitis, on arrival. Plasma, blood, oxygen, sulfadiazine and penicillin were given during the first 24 hours after his entrance to the hospital. Decompression was also instituted. Slight improvement was observed and on the day after admission, using local anesthesia, the appendix, with a large perforation near the base, was easily removed and a drain placed in the right lower abdomen. At this time, free pus was seen in the abdominal cavity. Cultures of this purulent material subsequently yielded Escherichia coli and Streptococcus viridans. Death occurred on the first postoperative day. Autopsy disclosed diffuse peritonitis, paralytic ileus and acute glomerular nephritis.

Case 2. — A white male, 7 years of age, entered the hospital after 5 days of illness. His temperature was 98.6° F. and there were signs of diffuse peritonitis. A perforated appendix was removed and the abdomen was drained. During the next 24 hours, 400,000 units of penicillin, 200,000 units (0.2 gram) of streptomycin and 4 grams of sulfadiazine were administered. However, the child died 24 hours postoperatively. Autopsy showed diffuse peritonitis.

Case 3. — A white male, 2 years of age, was ill for 3 days and was sent to the Municipal Contagious Hospital as a poliomyelitis suspect. He was then transferred immediately to this hospital. On arrival, he was in coma and extremely toxic. The temperature was 103.6° F. and the leukocyte count was 5,800 with 22 per cent polymorphonuclear cells. It was decided that operation should not be done because of his moribund state. Large doses of penicillin and streptomycin were given but he expired in 36 hours. Autopsy showed perforation of the appendix and diffuse peritonitis.

In the management of the 53 patients with diffuse peritonitis following perforation of the appendix, 52 (all except case 3 above) had appendectomies performed through a muscle-splitting incision. Perforations varied from pinpoint in size to a complete break in continuity. The stump of the appendix was ligated and turned in with a purse-string suture unless the edema and friability of the wall of the cecum made inversion impossible. Some of the peritoneal exudate for bacterial culture was invariably obtained. Drainage was instituted in all but 7 cases. If the peritoneal reaction and contamination were slight, drainage was not used or the drain was placed only to the peritoneum. A soft, rubber, Penrose tubing was used. If there was a large amount of purulent exudate, the abdominal cavity was drained paying special attention to the retrocecal area. There were no complications attributable to the drainage.[5]

Intraperitoneal chemotherapy was not used since it has been adequately shown that parenteral therapy is just as effective. Postoperatively, penicillin in an average dose of 30,000 units every 3 hours was given for 7 to 10 days.* Streptomycin, 100,000 units (0.1 gram) every 3 hours, was usually given for 4 to 8 days. In addition, sulfadiazine was frequently administered in a dosage of 1 grain per pound of body weight daily for 3 to 4 days, either intravenously or subcutaneously.

The duration of specific anti-bacterial therapy varied with the amount of peritoneal contamination and the clinical course of the patient. In cases where ileus was either present or anticipated, continuous suction with a Levine tube was used. Parenteral fluids and blood transfusions were given as needed. In 7 cases, prolonged drainage from the wound or abscess formation occurred but these subsided with proper management.[5]

II — PATIENTS WITH PERFORATION AND ABSCESS FORMATION

Fifteen patients with perforation of the appendix and abscess formation were treated without a fatality. In the management of these cases, 11 were treated conservatively. After the abscess mass was palpated (in several instances only after administration of an anesthetic) a regimen consisting of measures to combat the infection and inhibit the activity of the gastrointestinal tract was instituted. Sulfadiazine, penicillin and streptomycin were given as indicated. Parenteral fluids, blood transfusions and continuous gastric suction were continued until the clinical improvement allowed resumption of oral alimentation. Interval appendectomies, with

*One of the preparations which is more slowly absorbed and requires less frequent administration may be used.

good results, were done in these patients from 3 to 6 months after the abscesses subsided.

Four patients in this group presented problems in management which warrant a more detailed description of their case histories.

Case 4. — S. J., a white female, 5 years of age, became ill 2 months before admission. Four days after her illness began, the appendix apparently ruptured. She was admitted to another hospital and penicillin was administered for 3 weeks. After returning to her home, she continued to have fever and a painful mass appeared in the right lower abdomen. Three and one-half weeks later, this mass ruptured through the abdominal wall. Large amounts of purulent and fecal material drained through the opening. Further inadequate amounts of penicillin were given and she was admitted to Children's Memorial Hospital in a state of marked emaciation. Chemotherapy, antibiotics and vigorous supportive measures were necessary to rehabilitate her. Counter drainage of the huge abscess cavity was required. After 5 months of illness, the fecal fistula in the right lower abdomen was closed and normal weight was regained. Appendectomy, with considerable difficulty because of dense adhesions around the appendix, was then performed. Complete recovery followed.

Case 5. — B. S., a white female, 10 years of age, had pain in the right lower abdomen and fever for 4 weeks. She was admitted to this hospital and an orange-sized, tender mass in the right lower abdominal quadrant was palpated. Her temperature ranged from 103° to 104° F. Three days of therapy with pencillin, streptomycin and sulfadiazine did not lower the temperature and the mass began to increase in size. Drainage through a small muscle-splitting incision in the right flank was instituted. Two months later, an interval appendectomy without difficulty was performed. Recovery followed.

Case 6. — S. P., a white male, 5 years of age, had been ill for 5 days. On admission, his rectal temperature was 103.6° F. Tenderness, rigidity and a mass were present in the right lower abdomen. A muscle-splitting incision was made, the ruptured appendix was easily removed and the abscess drained. Postoperatively, penicillin, streptomycin and sulfadiazine were given for 8, 11 and 12 days respectively. Uncomplicated recovery took place.

Case 7. — S. M., a white male, 9½ years of age, was well until 8 days before admission when generalized crampy abdominal pain and vomiting occurred. Twenty-four hours later, the pain became constant in the right lower abdominal quadrant. Three days after onset, he felt better and went to school but he still had pain in the right lower abdomen. Two days before admission, pain on urination, nausea and vomiting were noted. He continued to feel ill and when admitted, a mass in the right lower quadrant, 6 x 6 cm. in size, was observed. A conservative regimen, including penicillin and streptomycin, was begun but on the day after admission, he suddenly vomited and became quite toxic. His temperature rose from 100° F. to 103° F. and the abdominal findings indicated a spreading peritonitis. It was felt that he was too toxic to allow operation at this time. For the next two days, marked improvement took place. Subsequent physical examinations and abdominal roentgenograms (flat films) indicated that a large abscess in the right half of the abdomen was present. Nine days after admission, surgical drainage was performed with removal of a large amount of purulent foul-smelling fluid. Drains were inserted. After 10 days, the drainage subsided and the drains were removed. The patient again became toxic and the temperature (which had been normal) became septic in type. Roentgenograms were suggestive of a right subphrenic abscess. A subcostal extraperitoneal approach to the anterior subphrenic area disclosed an abscess containing a large amount of pus. Drains were inserted and the patient promptly improved. Two months after his discharge, he returned for interval appendectomy which was successful.

It is evident from the above case histories that not all patients with appendiceal abscesses will respond favorably to nonoperative treatment. In cases 4 and 5, earlier surgical drainage would have been helpful. In case 6, early intervention was of value and in case 7, several operative procedures were required. Undoubtedly, the best plan of management is to continue treating those patients who improve on a conservative regimen by nonoperative measures. An interval appendectomy may then be performed 6 weeks or more after resolution of the abscess. In those patients who do not respond properly to conservative measures (as manifested by continued fever, signs of spreading infection and toxicity) surgical drainage is indicated. If the appendix can be conveniently removed without further dissemination of the infection by breaking down protective barriers, it is well to remove it as in case 6. Removal of the appendix, in such circumstances, is probably safer than it would have been a decade ago because of the value of antibiotics and chemotherapy in overcoming the associated infection.

DISCUSSION

The fact that no deaths occurred in the 110 patients with acute and gangrenous appendicitis emphasizes the value of early diagnosis and prompt removal of the appendix.

The decrease in the mortality rate of appendicitis with perforation from 11.8 per cent in the early series (1921-1935) to 4.4 per cent in the present series is due to several factors. The

most important of these is the use of antibiotics and chemotherapy.

Griffin, et al.[2], demonstrated the usefulness of penicillin and sulfadiazine in appendicitis. Shaff, et al.[6], advocated the use of streptomycin and penicillin in peritonitis. The latter combination has been used most often at this hospital because infections due to both gram-negative bacilli and gram-positive cocci respond to these agents. However, the combination of penicillin and sulfadiazine is also effective against these organisms. If contamination seemed excessive, sulfadiazine, in addition to penicillin and streptomycin, was administered. Sulfadiazine may be given either intravenously or subcutaneously. The subcutaneous method of administration has been shown by Glaser and Lawrence[1] to be safe. It is particularly useful in infants whose superficial veins are difficult to find or use repeatedly. A 24 hour dosage of 1 grain per pound of body weight in a 5 per cent solution of sodium sulfadiazine in distilled water was recommended by Glaser.

Certain ancillary measures contributing to the lower mortality are less specific in character and rather difficult to evaluate. These are better anesthesia and improved postoperative therapy, such as, the more general use of parenteral fluids, blood transfusions, intestinal decompression and many other lesser aids not in use 15 years ago.

It is the general plan of management at the Children's Memorial Hospital to remove the appendix in a patient with diffuse peritonitis if the condition of the patient permits operation. Thus, the source of peritoneal contamination is removed. In patients with abscess formation, conservative management is followed unless some indication for surgical intervention arises. stances of appendicitis with diffuse peritonitis

The three fatal cases in this series were in-which became overwhelming in degree largely because of late recognition.

Some controversy exists over the treatment of appendicitis with perforation. Schulz[7] believes that in children, if a definite diagnosis of appendicitis with perforation is established, operation is not indicated. During a 20 year period, the percentage of operated cases (of appendicitis with perforation) at the Milwaukee Children's Hospital dropped from 90 per cent to 33 per cent. The mortality rate in the first five years of the study when 90 per cent of the cases underwent operation was 25 per cent. In the last 3 years of the study, when only 33 per cent of the cases underwent operation there were no deaths. During this latter period, sulfonamides and penicillin were used. Although, as stated above, our plan of management is not in complete agreement with that of Schulz, the results which he has reported are impressive and deserve serious consideration.

Huebner[3] reported 219 cases of appendicitis with perforation, all of which were treated by immediate operation. The appendix was removed if it was readily accessible and abscesses, if present, were drained. The wounds were packed open with a perforated rubber sheet containing a gauze pack. The mortality rate was 6.84 per cent. Huebner's patients were a mixed group of children and adults.

SUMMARY

1. In the four year period from January 1, 1946 to January 1, 1950, 178 patients with acute appendicitis were treated at Children's Memorial Hospital. The mortality rate was 1.6 per cent.

2. In 110 patients with acute and gangrenous appendicitis, there were no deaths. In the 1921 to 1935 series, there were 297 comparable cases with 3 deaths, a mortality rate of 1 per cent.

3. In 68 patients with appendicitis and perforation, there were 3 deaths, a mortality rate of 4.4 per cent. This shows a substantial decrease in the mortality rate compared with that of the 1921 to 1935 series in which it was 11.8 per cent.

4. The more favorable outcome in the later series is believed to be due principally to the use of chemotherapeutic and antibiotic drugs.

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Retrolental Fibroplasia

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A phenomenal amount of thought, time and money has been expended in this country during the past two decades in an effort to reduce premature mortality rate. Statistics prove that this effort has not been in vain. As Koenig[1] so aptly states, "The first chapter in the life of a premature infant is by all odds the most dramatic one. By the mere act of remaining alive, he achieves that so desirable result — the lowering of infant mortality."

However, we must pause to consider whether we may be salvaging these prematures, only to have a large percentage of them face a life of darkness and continue as wards of the state. In recent years, ophthalmologists, obstetricians, pediatricians and those interested in public health are becoming increasingly alarmed by an apparently new disease, retrolental fibroplasia.

Retrolental fibroplasia was first described by Terry[2] in 1941 as "a massive growth of embryonic connective tissue occurring in a meshwork of persistent tunica vasculosa lentis which is linked with prematurity." His belief was, "there is a definite relationship between the hyaloid vascular system which ceases to function at about 36 weeks gestation and retrolental fibroplasia." In short, the disease produces extensive destructive lesions in the eye which almost completely disrupt the normal structures. It is encountered most frequently in small prematures, usually affects both eyes, and causes blindness.

Kinsey and Zacharias[3] in their research, found no casual relation in parity, age of mother, RH type, duration of labor, type of delivery, analgesic or anesthetic. Heredity is said to be no factor in retrolental fibroplasia. However, only one generation has been studied thus far. Other factors[2] which have been considered as probable causes of fibroplasia are intraocular inflammation, precocious exposure to light, precocious closure of the ductus arteriosus and the foramen ovale, an increase or deerease of oxygen in the blood, the lower temperature of the premature infants in the ineubator in contrast to intrauterine fetal temperature, laek of adult maternal endocrine environment, precocious elevation of blood pressure, inability to digest and assimilate food including vitamins, physiological anaemia of prematurity, and trauma or intra-ocular hemorrhage introducing the process.

The most significant fact about retrolental fibroplasia is its association with prematurity. Klein[6] and Reese and Payne[7] believe that the matrix of the disease is present at birth. They consider the lesion angiomatous and note that there are associated hemangiomas in 20 per cent of the cases. They further feel there may be some relationship between this condition and maternal bleeding. Reese[7] also notes that skin angiomas are present in 1 per cent to 2 per cent of full term infants, 3 per cent to 10 per cent of normal prematures as compared to the 20 per cent seen in infants with retrolental fibroplasia. Terry[2] thought the condition developed after birth and that some resulting factor from the premature birth such as abnormal persistence of embryonic blood vessels, must be responsible. Heath,[8] in agreement with Klein, reports a correlation between retrolental fibroplasia and hemangiomas; however, he believes the condition is congenital but develops after birth. Owens and Owens[4] examined the eyes of all infants with birth weights of 4¼ lbs. or less admitted to Johns Hopkins Hospital from 1945-1950. According to their findings, the disease is not present at birth but the first changes occur when the babies are about 4 wks. old. On early examination, no difference can be detected between the eyes that subsequently develop retrolental fibroplasia and those that do not.

Some of Terry's[2] findings indicate that precocious exposure to light may be an important factor. He stated that the position in the nursery and frequency of examination are factors. Heath[8] considers the disease an edematous, hemorrhagic, proliferative process and believes that whatever will prevent excessive permeability

Presented at the August 1951 meeting of the Illinois Obstetrical and Gynecological Society at Moline, Illinois.

TABLE NO. 1
January 1, 1945-January 1, 1950.

	Admissions	Discharges	Retrolental Fibroplasia	Blindness, other causes.
Total	3,360	2642 or 79.6%	22	13
Under 1000 gms.	253	46 or 18%	3 or 6%	
1000-1249 gms.	275	137 or 50%	6 or 4.4%	3
1250-1499 gms.	352	243 or 66%	7 or 2.9%	5
1500-1999 gms.	1,041	876 or 84%	5 or 1.1%	4
2000-2499 gms.	1,439	1340 or 91%	1 or .01%	1

of the neurovascular tissue is indicated. Certainly, from all reports the incidence varies in different areas and in different nurseries in the same city.

Terry[2] reported an incidence of retrolental fibroplasia in 12 per cent of infants weighing three pounds or less. He stated that in his findings the ratio of fibroplasia in the premature and in full term infants was 81 prematures to 2 full term infants. Owens and Owens[4] examined the eyes of all premature infants admitted to Johns Hopkins at weekly intervals and report the average incidence as about 8 per cent in babies whose birth weight is between 3 and 4 lbs. However, they have found an incidence of 16 per cent in infants whose birth weight is less than three pounds. Hess,[5] in a study of 317 prematures, graduated from Sarah Morris Center, whose birth weight ranged from 1 lb. 6 ounces to 2 lbs. 12 ounces, records only 13 children or 4 per cent with retrolental fibroplasia.

To date only 22 cases have been reported from downstate centers (see table 1.) Dr. Donaldson F. Rawlings says, "This represents the follow-up of probably less than two thousand premature infants cared for under this Department's program, and discharged alive since 1943. There have been about 4,000 infants admitted to the Centers since 1943, with a mortality experience of approximately 20 per cent. This rather high rate reflects the fact that infants must weigh less than 5 pounds to be eligible for care, thus excluding the proportionately larger number in the 5 to 5½ pound weight group with its much more favorable survival rate. Then, too, our follow-up program began in 1945. Reports are made around the time of the infant's first birthday, and, therefore, many of those discharged since July, 1950 are not yet reported. We lose a number who move out of the state, die following discharge from the Center or who just seem to vanish."

This explains the low number estimated to be under follow-up observation. More accurate figures will be available within a few months. However, these reports from Dr. Rawlings are partial reports from the following counties — Cass, Greene, Macoupin, Madison, Peoria, Sangamon, Scott. St. Clair, Tazewell, Wayne, Fulton, Saline, Shelby, Whiteside, Franklin, Fulton, Henry, Livingston, Mason, Menard, Piatt, Williamson, Woodford, and Morgan.

The above table has been verified by letters from one of the attending physicians at each of the Centers. The East St. Louis Center reported the major portion of the above cases. Furthermore, from January 1, 1950 to July 1, 1951, East St. Louis has seen an additional 15 cases and Springfield only four cases, with Peoria reporting none.

In a recent conversation, Miss Sloan of the Division of Maternal and Child Hygiene told me that the state has now established a much better system of checking graduates from the centers. As soon as the program can be thoroughly established, a similar follow-up will be carried out throughout the downstate areas and more adequate and accurate statistics will be available.

In contrast to the number of cases reported from the downstate centers and from Sarah Morris, I quote a recent communication from Dr. Arlington C. Krause, Chief of the Division of Ophthalmology, University of Chicago, "We have about one hundred one retrolental fibroplasia cases (since 1937 at which time we had our first case.) About half of these came from the Chicago Lying-In Hospital and the other half came from outside. We have about five additional cases coming in to be examined later. We try to examine these children once a year and to follow them during their entire lifetime. Several of these children have been institutionalized, and

we have many, too young as yet, who will also be placed in state institutions."

Furthermore, in 1944, Dr. E. V. L. Brown[9] stated that a group of five ophthalmologists in Chicago had seen between 75 and 80 cases. This does not include the cases seen by Dr. Krause. This variation in statistics, to a certain extent, may be accounted for by Dr. Brown's statement, "The mother is almost always the one who discovers this condition. She usually, it seems, finds it while she is bathing the child and the light happens to strike the pupil just right and she sees the mass behind the pupil. Ordinary observation by other members of the family or by the family doctor or pediatrician may not corroborate what she has seen. We should give every mother who has a premature child, at least before the seventh month or of not over 3 to 3 1/3 pounds (1360 to 1587 gr.) of weight, instructions to carefully watch the child's eye throughout the first year. There are no reports of cases starting after one year, and the onset is usually between the first and ninth months."

Dr. Watson Gailey reports having seen some thirty odd cases in the past year and stated, "After checking all of our cases of retrolental fibroplasia, we found that we had two cases which were monocular and two cases which might possibly be able to avoid becoming wards of the State. However, these cases will be sight saving class students throughout the majority of their education."

Dr. George Drennan, physician at the Illinois School for the Blind, has checked their records and found that of 177 children enrolled last year, 17 are reported as having been born prematurely. Of these 17 prematures, 4 are listed as cases of retrolental fibroplasia. One, who chances to be the first case recorded in Illinois, and a Sarah Morris graduate, completed High School this June. Of 87 preschool children seen at the Institute for Parents of blind children during the past two years, 24 gave histories of having been born prematurely, and the causitive factor in 17 of these cases is recorded as retrolental fibroplasia. These cases have been quite evenly distributed from premature stations over the state.

From Krause, Brown, and Gailey's reports it is obvious that not all of the cases have been reported from the centers either in the metropolitan area or downstate. However, the services of an ophthamologist has been engaged at each of the downstate centers and it is hoped that more accurate studies and follow-up is assured for the future. Even with these findings, the incidence in Illinois is obviously, and may we also add, fortunately below the 10 per cent to 15 per cent reported in the east.

Terry[2] stated that treatment through direct surgical attack, through use of radiation, or through an attempt to seal the hyaloid artery with diathermy ended disastrously. However, if no treatment is given, there is a spontaneous reduction in the amount of opaque tissue in some instances, but the eyes usually fail to grow normally. Brown[9] mentions that retrolental fibroplasia must be differentiated from glioma retinae-neurablastoma, and that prior to Terry's description of the disease due to an error in diagnosis he had needlessly removed several eyes. Heath[8] emphasizes that in planning therapy, whatever will prevent excessive permeability of the neovascular tissue is indicated. Furthermore it may be wise to consider Terry's admonition regarding frequent examinations and excessive light as a causity factor. Certainly the Owens[4] incidence of 16 per cent retrolental fibroplasia, as compared to Hess[5] 4 per cent in babies weighing under 3 lbs. should give pause for thought before making too frequent ophthamological examinations. However, ophthamologists with whom I have discussed the condition give little credence to light as a causitive factor.

Actually, there is no known established therapy, for once the process has started, it is usually progressive and bilateral. Prevention is a prime consideration. Certainly, the obstetrician should and must do all in his power to prevent premature labor. In 1948 Dunham[10] estimated that approximately 150,000 premature infants are born in this country each year. Of these around 4 per cent or 6,000 weigh less than 1,000 grams at birth and only 15 per cent, or 900, may be expected to survive. Approximately 7 per cent, or 10,500 premature babies weigh 1,000 to 1,500 grams and of these 60 per cent, or 6,300, may be expected to survive. If, as has been anticipated, 10 per cent of these will develop retrolental fibroplasia, we may anticipate more than 700 new cases each year. For it is this group that develop the high incidence of retrolental fibroplasia — this group whose stay in utero we must endeavor

to prolong if we hope, not only to reduce the premature mortality rate, but also to lower the incidence of retrolental fibroplasia.

Heath[8] remarks that there seems to be some correlation between the increased frequency of retrolental fibroplasia and the use of water soluble, vitamin A & D supplements and the increased use of iron. The Owens emphasize that the most fruitful investigation is to be found in the post-natal course of the infant, and they are studying alterations in the metabolism which might be related to retrolental fibroplasia. They are working on the basis that the disease is metabolic in origin; the first changes in the disease occur when the baby is about one month old, and, at this time, the storage of essential metabolites is probably depleted. These infants almost uniformly manifest a low fat tolerance and are on low fat diet. Possible deficiencies of fat soluble, vitamin A, D, and K, are usually prevented by adequate substitutes. They stated in 1949 that vitamin E alone usually has not been added, and it plays an important role in protecting and stabilizing unsaturated fats during their mobilization. They have tried using a special water-miscible preparation of d-1 alpha tocopheryl acetate, a form of vitamin E, with promising results. However, the East St. Louis Center has tried vitamin E for a year with no change in incidence.

For the past year Reese and Blodi[11] have been using ACTH in the treatment of infants who developed retrolental fibroplasia. Their work is based upon the theory that retrolental fibroplasia is a disease of the blood vessels. Since hyperadrenalism inhibits growth of mesenchymal cells and cortisone specifically inhibits the growth of capillaries, it seemed reasonable that ACTH might halt the vascular overgrowth which marks the beginning of retrolental fibroplasia. In a series of 13 infants showing early evidence of retrolental fibroplasia, they used 20 to 25 mg. of ACTH daily for two weeks and the progress was arrested. However, in two, after cessation of therapy, progress reactivated and ACTH was again used with regression of the process. In eight infants where no ACTH was used, the lesions progressed to bilateral blindness.

In conclusion, may I say that retrolental fibroplasia is a disease of small premature infants which is believed to be either vascular or metabolic in origin with a probable congenital factor. It does not first manifest itself until the infant is approximately three or more weeks old. The disease was first described just 10 years ago and is increasing at an alarming rate. This increase parallels the increased salvage of very small prematures. At the present rate of increase, authorities estimate that retrolental fibroplasia will soon be one of the chief causes of blindness in our schools for the visually handicapped. There is no known established therapy. However, it is thought that there may be some relationship between the administering of water miscible vitamins and iron. Vitamin E, in the form of d-1 alpha tocopheryl acetate is being used prophylactically with ambiguous results. ACTH is being used therapeutically with quite promising results. The main problem is one of prevention. This problem is primarily the obstetrician's, for by prolonging the infant's stay in utero, we may anticipate a concomitant increase in birth weight. Coincident with the reduction of the birth of very small prematures, there should be not only a reduction in premature mortality but also a reduction in the incidence of retrolental fibroplasia.

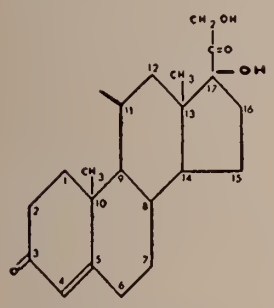
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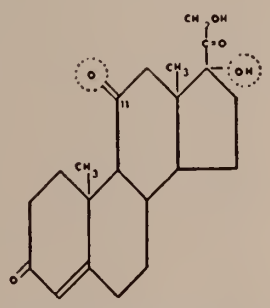
Clinical Results Obtained With Reichstein's Compound

John Peters, M.D.
Oak Park

Desoxy-cortisone, also known as Reichstein's Compound S. has recently been synthesized from soy bean oil by the well-known bio-chemist Dr. Percy Julian. It differs from Cortisone only in that it does not possess the oxygen molecule at C 11.



Desoxycorticosterone
Reichstein's Substance S



11-dehydro-17 hydroxycorticosterone
(Compound "E")

Its presence in the adrenal cortex has been demonstrated by active isolation and the compound has been proven to possess a high degree of mineralo-cortical potency. This compound has been of special interest to me because of its pharmacological similarity to Cortisone. Through the courtesy of the Glidden Corporation, manufacturers of this steroid, I was supplied with material for investigative purposes. The cases selected for therapy were those that did not respond to any other form of treatment. I hereby report these cases and the results obtained.

CASE 1: G.A.D. Male, age 28, with a history of bronchial asthma for the past ten years. Laboratory and clinical tests were essentially negative. Various forms of therapy, including climatic changes, were of no benefit. Temporary relief was obtained from the use of epinephrin and aminophylline.

One year ago he was injured in an automobile accident, with considerable shock to his nervous system. His asthma abruptly disappeared and he remained free of symptoms for a period of three weeks. When he recovered from his shock and injuries his asthma recurred, with no relief for the past eight months. He was selected for therapy with Reichstein's Substance S, with the following results:

Before Therapy:		Four Hours After 25 mg. Reichstein's Substance S
Blood Pressure	114 / 75	150 / 90
Eosinophilia	1196	292
Pain Threshold:		
Sensation	0.7	0.65
Pain	1.1	0.85
Encephalogram	No abnormalities	No changes

Twenty-five milligrams of Reichstein's Substance S was given daily for a period of seven days. His asthma improved, his appetite increased, he was more active and had a sense of well-being. For a period of three months this patient believed that he was permanently cured. Several days ago, however, this patient returned with a recurrence of symptoms. He was given ten milligrams of Reichstein's Substance S Acetate daily for four days, and all symptoms abated.

CASE 2: D.K. Male, age 21, with a history of bronchial asthma since childhood. His attacks were not influenced by inhalants, ingestants, season or climate. On skin tests he gave a 1 plus reaction to pollen and dusts. He has been treated accordingly for several years without noticeable improvement.

He is emotionally unstable, mentally immature, and restless most of the time. About six weeks ago this young man developed severe asthma and failed to respond to any therapy. He was selected for therapy with Reichstein's Substance S Acetate, with the following observations:

BEFORE THERAPY:		FOUR HOURS AFTER 25 mg. REICHSTEIN'S SUBSTANCE S
Blood Pressure	115 / 80	140 / 90
Eosinophilia	627	342
Pain Threshold:		
Sensation	.55	.40
Pain	1.4	0.9
Encephalogram		Normal

This patient was given twenty-five milligrams daily of Reichstein's Substance S for a period of seven days. His asthma abated, his appetite improved and he gained weight. Although Reichstein's Substance S has been discontinued, he has had no symptoms of asthma for the past six months.

CASE 3: Male, age 60, with a history of bronchial asthma for the past five years. Skin tests and all laboratory procedures were essentially negative. Patient wheezes fairly constantly. He has not responded

to any therapy. He was hospitalized for investigative purposes.

	BEFORE REICHSTEIN'S SUBSTANCE S:	24 HOURS AFTER 25 mg. REICHSTEIN'S SUBSTANCE S:
Blood Pressure	150 / 90	170 / 90
Eosinophilia	350	50

He was given 25 mg. Reichstein's Substance S at four hour intervals. Within a period of four days this patient became symptom free. His appetite increased, he was able to sleep flat on his back for a period of eight hours without interruption. He was active most of the day without fatigue. Therapy with Reichstein's Substance S was discontinued and shortly afterwards his symptoms recurred.

CASE 4: White female, age 11, was admitted to the hospital with a diagnosis of lupus erythematosus disseminatus, based on skin biopsy and bone marrow study. The patient was unable to retain food; the lips and gums were ulcerated; there were typical skin lesions, swollen and painful joints and she was not able to flex them. She coughed constantly, expectorating large quantities of thin and frothy mucus. There was present a moderate cervical and sublingual lymphadenopathy. The heart was enlarged, with a low blowing systolic murmur, with fine moist rales at base of lungs. Patient was placed on Reichstein's Substance S, 50 mg. four times a day with dramatic results. Four days after treatment had started all pain had disappeared; the patient was cheerful and able to retain food; her cough had subsided; the bluish coloration of her fingers and lips had taken on a pinkish hue. She was able to walk for the first time in four months. This condition remained stationary for the next ten days. At this time she became restless, irritable, and complained of deep muscle pain. In spite of changing Substance S dosage no improvement was noted. Edema appeared on the feet and neck and became more pronounced until January 26, involving the feet and extended to the lower third of the legs, as well as the hands and face. The patient became very toxic, expectorated bloodtinged mucus and was very dyspneic. Examination at this time revealed evidence of effusion in the base of the left lung posteriorly. There were also coarse, moist rales heard over the right base. She expired two days later, death being due to pneumonia.

CASE 5: Female, who in 1940 developed migraine headaches. They continued for a period of three years and subsided following radium therapy for uterine fibrosis. Several months later she developed giant urticaria, followed by generalized convulsions. A diagnosis of epilepsy was made and was treated accordingly, with no improvement. A trephine of the skull was done to determine the possibilities of intracranial lesion, with negative findings. She was referred for allergic study. The patient was carefully checked, including skin tests; she was placed on a selective diet; all possible irritating factors eliminated, and with the aid of antihistamines her urticaria improved, but at no time was she completely free from hives. This routine was followed for a period of one year. During this time this patient had approximately six convulsions, which always followed an attack of severe angioneurotic edema and urticaria.

	BEFORE THERAPY:	AFTER 25 mg. SUBSTANCE S
Blood Pressure	120 / 80	160 / 90
Eosinophilia	462	252
Pain Threshold:		
Sensation	1.0	0.65
Pain	2.6	0.85
Urticaria		Completely disappeared
Encephalogram:	Alpha waves above normal	Alpha waves greatly diminished
Mental attitude:	Depressed	Stimulated and pleasant
Appetite	Fair	Increased to constant hunger

For a period of seven days this patient was given 25 milligrams Reichstein's Substance S per day.

The following is a written statement given by the patient:

1. Double vision diminished from six to eight attacks per day to every other day.
2. Eyes bloodshot only occasionally, where previously every day.
3. Gaint hives practically eliminated.
4. General swelling completely disappeared. Throat and tongue swelling completely disappeared. Hot flashes eliminated.

Although this patient has not been treated for the past four weeks with Reichstein's Substance S, she has been almost free of hives and has had no convulsions during this period. She has steadily gained in weight and her personality changed completely.

Six weeks following the discontinuance of Reichstein's Substance S her urticaria recurred and she apparently believes she had a nocturnal convulsion, based upon the fact that she noticed blood spots on her pillow.

CASE 6: Male patient, age 65, in good health until age of 26, when he developed localized psoriasis on his legs and arms. After several years his psoriasis became progressively worse, involving his entire body. He did not respond to any form of therapy. Several months ago (March, 1951) he developed severe pain and swelling of both ankles, forcing him to remain in bed. He was hospitalized and was given daily a one-half cc of Reichstein's Substance S for a period of 25 days; one-half cc every other day for a period of two weeks, and at present he is getting a one-half cc twice weekly. His pain and swelling in the ankles began to improve on the fifth day following therapy, and within a period of ten days his swelling and pain completely disappeared. His psoriasis also began to improve after two weeks of treatment and at present, which is about three months since beginning of therapy, he is completely free of psoriasis and arthritic pain. He has gained ten pounds of weight and has returned to work.

CASE 7: Female patient, age 30, daughter of the above patient, has been in perfect health until ten years ago, when she developed psoriasis of the scalp only. Has been under the care of several dermatologists

without any sign of improvement. In May, 1951, she was given daily one-half cc of Reichstein's Substance S for a period of ten days, one-half cc every other day for two weeks, and at present one-half cc twice weekly. Her psoriasis has almost cleared, with the exception of a small area of about two centimeters in diameter on the lateral side of her scalp.

In each of our cases described the initial results were very encouraging. There were definite marked improvements in their symptoms. Their appetites improved; several patients gained weight on a routine diet. Improvement in strength was frequently observed. Fatigue and effort syndromes were noticeably diminished. Increased mental capacity and activity were noticed in all of them, and with it a sense of well-being. The laboratory findings of any significance were a decrease or a complete disappearance of eosinophilic cells. The sedimentation rate was not affected. In order to provide adequate control, Reichstein's Substance S Acetate was replaced by placebos and within several days the patients complained of recurrence of symptoms.

SUMMARY

Reichstein's Substance S Acetate was given to seven patients with the following diseases; One case of lupus erythematosus disseminatus, One case of chronic urticaria, complicated by convulsions, Two cases of psoriasis, Three cases of bronchial asthma.

The response of the patients with lupus erythematosus disseminatus, urticaria with convulsions, and two patients with psoriasis were dramatic. The three cases of bronchial asthma apparently greatly benefited. All of them showed a definite fall in circulatory eosinophilia. Our investigation with Reichstein's Substance offers adequate proof of its therapeutic value. Cases selected were only those that failed to respond to routine therapy.

These observations indicate the relationship between the endocrines and the nervous system, and their interaction apparently maintains the organism in equilibrium. These changes do not necessarily have to be organic in character. Stress in any form may be a powerful factor in disorganized function.

These observations are of paramount importance to the medical profession because they offer a new concept in "meaning of disease" and quite likely will provide a different approach in management of the same. We cannot deny that all the steroids have produced amazing results in many instances and disastrous results in others. Nevertheless, we must admit that in a search for a solution to disorganized function the miraculous has not "yet" been found in any of the steroid hormones as there are many blanks in the prospective, many by-ways to be explored and many complicated questions to be answered.

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'NOTE' — In order to shorten this paper I am reporting our results in a very small number of cases. Our experiences in approximately fifty other cases are similar to those described and will be reported in subsequent publications.

THE NATURE OF ALLERGY

. . . Infants, especially those with allergic ancestry, should have human milk for sometime after birth until the lining of their alimentary tract has had a chance to complete its development. It means, as well, that all through life such individuals should have a diet rich in vitamin A to help insure the integrity of all of their mucus membranes. It further means that the expectant mother with an allergic ancestry should have a balanced menu of foods well digested so that she does not send some undigested foodstuff through her placenta into the circulation of her unborn child. For her, the rule must always be everything in moderation and meals taken in pleasant surroundings to insure their digestion. Such is the nature of allergy! *Excerpt: Allergy, Jonathan Forman, M.D., O.S.M.J., June* 1951.

Superficial Fungus Infections —

The Direct Mount and Culture in Tinea Pedis

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Eruptions of the fect in the majority of cases suggest to the average clinician the possibility of a fungus infection. This is rightfully so, but unfortunately, in many instances the diagnosis is incorrect. The differential diagnosis must include dermatoses due to external irritants, psoriasis vulgaris, secondary syphilis, dyshydrosis, bacterial dermatitis, acrodermatitis continue etc.

The direct microscopic examination of scrapings of skin from infected areas offers the best proof of a mycotic ctiology. The procedure is a relatively easy one and requires so little time and equipment that we feel that it does not have wide enough use[1].

Cultural techniques carried out in addition to the direct mount unquestionably confer certain advantages. The exact strain of the fungus responsible for a clinical condition can be isolated and studied. The lack of response to the usual antimycotic therapy occasionally encountered may thus be explained, as for example, in *Trichophyton purpureum* infections. It is also of value in epidemiological investigations, such as in tinea capitis in children. Neverthelss, in spite of these advantages, where a rapid and positive diagnosis of a mycotic infection of the skin is desired, the direct mount is definitely more practical than the more time consuming cultural methods. Also, we feel that it is not widely enough appreciated that, in a large number of instances, the cultures fail where the direct mount is positive. In order to emphasize the advantages of the slide over the culture, the results obtained from 1000 consecutive individuals suffering from what appeared to be a possible tinea pedis were studied.

Materials and Methods.—Skin scrapings from the periphery of lesions and/or the roofs of intact vesicles were taken. These were placed on a slide, a drop of 10% KOH and a cover slip were added, the preparation warmed gently to facilitate clearing and the slides studied microscopically for the presence of mycelial elements.

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At the same time, other scales from the same areas were dipped into 70% alcohol and then placed on the surface of Sabouraud's dextrose agar slants. These were incubated at room temperature for a minimum of three weeks before negatives were discarded. Difficulties with contaminants by this procedure were inconsequential. All positive cultures were identified according to genus by the methods of Conant et al[2]. No attempt was made to classify the Trichophyton group by species; the difficulties involved in the definitive classification of this group is well known, and further identification was outside the scope of this study.

Results.—Positive KOH mounts were obtained in 488 cases or 48.8% of the 1000 individuals studied; of these 158, or 32.4%, were positive by culture. Of the 512 negative direct mounts only 3.9% were positive by culture. There were 11 times as many Trichophyton isolated as Epidermophyton. From two cases, both Trichophyton and Epidermophyton were grown. The possibilty of mixed infections of this sort must be kept in mind — they may account for some treatment failures. *Candida albicans* was isolated only twice in this series.

Discussion.—It appears true that fungi can sometimes be isolated from apparently normal skin. Strickler and Freedman[3] reported the amazing figure of 44.8% positive slides from 157 clinically normal skins. Ajello *et al*[4] found but 1.7% in 359 cases, and Burgess[5] could not demonstrate any pathogenic fungi from 100 normal feet. We have found fungi so rarely in individuals with no clinical evidence of mycotic infection or other dermatoses that we feel that the demonstration of fungus elements is almost definitely diagnostic of infection.

Other investigators have also found that the percentage of positive direct mounts was significantly higher than that obtained by culture, and that cultures rarely succeeded where the direct mount was negative, with the sole exception, of

DEMONSTRATION OF FUNGI BY DIRECT MOUNT AND BY CULTURE FROM 1000 CASES OF POSSIBLE TINEA PEDIS

	NO.	%
POSITIVE DIRECT MOUNT	488	48.8
A. CULTURE POSITIVE	158	32.4
Trichophyton	138	87.3
Epidermophyton	12	7.6
Microsporum	6	3.8
Candida albicans	2	1.3
Mixed Trichophyton and Epidermophyton	2	-
B. CULTURE NEGATIVE	330	67.6
NEGATIVE DIRECT MOUNT	512	51.2
A. CULTURE POSITIVE	20	3.9
Trichophyton	14	70.0
Epidermophyton	6	30.0
B. CULTURE NEGATIVE	492	96.1
TOTALS	1000	100.0

course, of *Candida albicans*. Hopkins *et al*[6] in 1213 cases found cultures positive when the direct mount was negative in only 4.5% and Ajello[4] in 11%. Only 3.9% of our negative KOH mounts resulted in a positive culture. The ratio between Trichophyton and Epidermophyton found agrees favorably with that reported by Hopkins *et al*[6], Lewis and Hopper[7] and most other investigators who studied similar series.

Several factors must be considered to account for the reasons why cultures fail so frequently where direct mounts are positive:

1. Technical factors — improper selection of material, poor technique, overgrowth by contaminants and very likely, gross nutritional deficiencies in the widely used Sabouraud's medium.

2. Difference in the rate of growth of the etiological agent. For example, *Trichophyton mentagrophytes* grows much more rapidly than *T. violaceum*, hence cultures should be observed for at least three weeks before being discarded as negative.

3. The possibility that the mycelia seen in the alkali preparations are those of non-pathogenic fungi. This is considered remote since they rarely proliferate on skin[8] and the microscopic picture of the pathogenic fungi is typical. The so-called "mosaic fungi" which some observers believe are actually fungus elements, present no difficulties since they are readily distinguishable from true mycelial elements. We have been unable to recover fungi from mosaic positive material in numerous attempts.

4. Previous treatment of the patient under study is unquestionably an important factor. It seems reasonable to postulate that treatment with powerful medicaments may so affect the organisms that they fail to grow. However, in this series, in the soldiers studied by Hopkins *et al*[6] and the veterans by Burke and Bumgarner[9], very few of the individuals had had any recent therapy, nevertheless, the culture rate was very low as compared to the direct mount.

SUMMARY

1. In a series of 1000 cases of possible tinea pedis, 48.8% were positive for fungi on direct mount. Of these 488 cases, only 32.4% were positive by culture.

2. Reliance on a properly prepared direct KOH mount of a scraping from the feet should, in a high percentage of cases, be sufficient to establish the mycotic etiology of an infection. This is of the most practical importance, since it dictates subsequent therapy. The addition of the culture method, although ideal, is of limited value except under special circumstances.

3. Possibilities to account for the low percentage of positive cultures as compared to the positive direct mounts are discussed.

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The Mechanism and Treatment of Pulmonary Edema

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Dr. Luisada: My interest in pulmonary edema began twenty-four years ago when I first studied experimentally this intriguing syndrome. Many advances have been made since then, but our knowledge of its mechanism and of its treatment is still incomplete. So-called pulmonary edema can be acute, subacute or chronic. Actually, it should not be termed "edema" because it is a transudation or exudation of fluid from the blood vessels into the alveoli. The intermediate tissue is so thin that this transport may occur quite readily. The typical picture of acute pulmonary edema is well known, being characterized by paroxysmal dyspnea, apprehension, oppression in the chest, expectoration of white, yellowish, or pink-tinged foam, and pulmonary moist rales. This syndrome of acute pulmonary edema may have many etiologies. I should like to outline the multiple possible causes:

(a) Heart disease, regardless of etiology. I have seen pulmonary edema during the course of luetic, rheumatic, hypertensive or any other heart disease: in angina pectoris, in acute or chronic cor pulmonale, in glomerulonephritis, in uremia, and in cardiac failure from any cause.

(b) Injury to the central nervous system. Pulmonary edema is not infrequently seen 24-48 hours after trauma to the skull, in subarachnoid hemorrhage, or in cases of encephalitis, meningitis, poliomyelitis, tetanus, cerebral abscess or tumor, or after cerebral vascular accidents.

(c) Respiratory diseases. The condition may be seen in pneumonia, particularly the influenzal type; after inhalation of toxic gases, or in drowning; if either fresh or salt water gets below the vocal cords it often gives rise to acute pulmonary edema.

(d) Allergy. This field, so far, is poorly documented. Pulmonary edema has been reported to occur following serum sickness, angioneurotic edema, or following administration of (and sensitization to) gold preparations.

(e) Metabolic and endocrine disorders. There have been cases of pulmonary edema in conjunction with beri-beri, heart disease and thyroid crises.

(f) Stimulation of hollow viscera. Sudden over-distention of esophagus, stomach or gall bladder may lead to pulmonary edema; or the too rapid emptying of a distended viscus, such as an obstructed bladder; or the stimulation of serous membranes like that following thoracentesis or paracentesis. One word of caution: much is said about these factors in older literature but recent discussions do not appear to confirm this particular etiology.

(g) During the management of surgical and obstetrical patients, pulmonary edema may follow blood transfusion, or infusion, or manipulation of the stellate ganglion; it may occur in eclampsia, particularly in those patients in whom the syndrome is associated with heart disease.

(h) Toxic conditions. Experimental evidence indicates that thiourea, iodides, muscarine, eserine or methyl salicylate in toxic doses give rise to acute pulmonary edema in animals. The doses by which it is initiated, however, are such that this particular effect of these chemicals does not appear to be of clinical significance in man except in cases of poisoning.

Of all the elements which I have listed, the one

which must be singled out and emphasized is the increase in incidence of pulmonary edema in those hospitals where transfusions and infusions are used freely. Twenty-five years ago this complication of surgical and obstetrical cases was rare.

The *experimental approach* to pulmonary edema may be twofold: First, critical observation of clinical cases of various etiology; and second, conclusions from studies on animals. Pulmonary edema has been produced in animals through several mechanisms: (1) The ligation of the aortic arch in rabbits; (2) The intravenous injection of large doses of epinephrine, also in rabbits — this causes death within 20 minutes: (3) Rapid intravenous and intra carotid infusion of normal saline solution. In dogs, the amount of saline necessary to produce pulmonary edema is smaller if the solution is given by carotid than by vein. Infusions may be of saline, whole blood, or plasma. Several drugs, as well as denervation of the carotid sinus, may prevent the development of pulmonary edema following such infusions. (4) Suboccipital injection of fibrinogen and thrombin, or veratrine leads to arterial hypertension and pulmonary edema. (5) Vagotomy in the rabbit or guinea pig. (6) Injection of silver nitrate or alcohol into the ventricular wall of dogs. (7) Ingestion of ammonium chloride in guinea pigs.

Clinical experience and laboratory findings permit one to outline the *factors* which are necessary for the development of pulmonary edema. These include:

A. High blood pressure in the capillaries of the pulmonary circulation which may be due to —
 1. increased cardiac dynamics with increased peripheral resistance
 2. increased venous return if either left ventricular failure or mitral stenosis is present
 3. pulmonary vasodilatation due to sympathetic stimuli (this is still hypothetical)
 4. extreme bradycardia

B. Increased permeability of the pulmonary vessels which may be caused by —
 1. a primary factor, e.g. allergic, or to "histaminergic" stimuli
 2. the suction effect of dyspnea
 3. the cytotoxic effects of anoxia

C. Decreased osmotic pressure due to
 1. nephrosis
 2. saline infusion
 3. starvation

There is discussion in the literature regarding *neurogenic components* in the development of pulmonary edema. Neurogenic stimuli act through the autonomic nervous system and can affect several levels of these three major components as outlined above. Thus the peripheral resistance, the venous return, the heart rate, the respiratory behavior, the pulmonary vascular tone and the pulmonary exchanges may be regulated by nervous control. Whether the capillary permeability is also affected is open to question.

Treatment of choice in pulmonary edema depends on the etiology in the particular case. Many drugs have been suggested. A consideration of these drugs, their indications, contraindications and mechanisms is given in Table 1. The last item on this list, alcohol inhalation, bears further comment. In respiratory dynamics, a reasonably good exchange of gases can take place even in the presence of a fair amount of fluid. However, as soon as foaming develops, gaseous exchange becomes progressively impaired. Diminution in effective air exchange leads to tissue *anoxia;* tissue anoxia, to further pulmonary edema; pulmonary edema, to further anoxia. This cycle must be broken. To treat the syndrome effectively, I tried several agents in animals with the objective to reduce surface tension and thus diminish the amount of foam in the bronchi and lungs. Several substances were found which effectively prevent foaming, but most of them had undesirable side effects. Alcohol proved to be the least harmful. Inhalation of 95% ethyl alcohol by a spray or as a vapor mixed with oxygen gave rise to an immediate decrease in the foaming tendency and in the mortality of animals in experimental pulmonary edema. On the basis of these experiments, we have treated a number of patients with acute pulmonary edema, using alcohol vapor with very good clinical results. The quantity of alcohol absorbed is minimal. The patients do not even get dizzy, and I am convinced that several lives have been saved through this technique alone. To illustrate the anti-foaming properties of alcohol, one can take normal plasma and bubble oxygen through it to form an immense "head of foam" — this is readily dis-

Table 1
TREATMENT OF PULMONARY EDEMA

TREATMENT	INDICATION	CONTRA-INDICATION	MECHANISM OF USE
Atropine (subc., i.v.)	Coronary occlusion	All other cases	Doubtful
Morphine (subc., i.v.)	Hypertension Heart failure Coronary occlusion	Allergy—Shock—Toxic gases—Pregnancy—Drowning—Neurol.	Decreased venous return—Slower respiration
Phenobarbital (p.os, i.v.)	Same	Same	Central sedation Decr. venous return?
Chloral hydrate (Rect., p. os, i.v.)	Same	Same	Same
Mercurials (i.v.)	Same	Same	Decreased venous return
Strophanthin-Digoxin-Digitoxin (i.v.)	Heart failure	Mitral stenosis—Coronary occl. Shock—Toxic gases	Increased myoc. efficiency Primary and secondary decreased venous return
Sympatholytics (i.v.)	Hypertension*—	Same	Decreased peripheral resistance (decreased pulm. vasodilation?
Aminophyllin (i.v.)	Same	Same	Decreased peripheral resistance
Antihistaminics (i.v.)	All cases, esp. allergy*	———	Decreased permeability
Vitamin P2 (i.v.)	All cases*	———	Same
Heparin	All cases*	———	Same
Oxygen (inhalation)	All cases	———	Decreased anoxia
Pressure respiration	Most cases	Shock	Resistance to transudation Decreased venous return.
Alcohol (inhalation)	All cases	———	Changes in surface tension Less anoxia Mild central sedation

*So far, tried only in experimental pulmonary edema.

solved with a few squirts of alcohol through an atomizer.

In summary, acute pulmonary edema is an extremely severe clinical emergency which may last for minutes to hours, and even days; the longer the patient survives, the more hope there is for his survival. Some patients will die no matter what efforts are expended. In others, a spontaneous tendency toward recovery is present. There is still a wide in-between, however, where therapy may well make the difference between life and death. Most of the remedies are still under experimental consideration in the treatment of pulmonary edema. In hypertension, such measures as morphine, phenobarbital, chloral hydrate and tourniquets decrease the venous return and often give prompt relief. In all other cases, oxygen without pressure and alcohol inhalation are the therapies of choice at the present time.

Dr. Alfred E. Leimdorfer, Associate Research Professor of Pharmacology and Therapeutics, Loyola University Medical School: I note that you did not mention hypertonic solutions in the

treatment of pulmonary edema. How do you feel about these? How do you feel about venesection?

Dr. Luisada: We have tried using hypertonic solutions in experimental pulmonary edema many times. Our results have not been striking. Venesection appears to be of greater value in patients with a high venous pressure.

Dr. Robert W. Keeton, Professor of Medicine, University of Illinois: What is the technique of giving alcohol to patients with acute pulmonary edema?

Dr. Luisada: The technique that we employ is very simple. We put 40% alcohol in the humidifier bottle rather than water, in the regular mask oxygen administration setup. Or we use 95% alcohol and a nasal catheter. Oxygen is started gradually and within a few minutes a local anesthetic effect is obtained and there is no more irritation from this concentration of alcohol in the inspired oxygen. If given by mask, the vapor is administered for a half hour; after this the patient rests for 15 minutes. Periods of administration of alcohol are then alternated with rest until improvement is noted. If given by catheter, administration is continued until improvement takes place. So far, we have reserved alcohol treatment for those very sevcre cases which were unresponsive to other measures. However, now that we feel certain of the beneficial effects, we apply it to all cases, whether or not other medication is given.

The Tuberculosis X-Ray Survey as a Medium for Early Diagnosis of Chest Malignancy

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With the introduction of the State-wide small film (70mm.) survey for tuberculosis, it was noted that occassional x-ray findings were not typical of tuberculosis but suggested a possible neoplasm. The potentiality of surveys of this sort as a means of discovering early malignancies of the lung became immediately apparent.

According to Snow[1] autopsy statistics show that from 10 to 20 per cent of deaths caused by cancer are due to primary carcinoma of the bronchus. In Table 1 it is seen that for the year 1947 deaths certified as being due to carcinoma of the bronchus, lung and pleura comprised only eight per cent of the total number of deaths certified as being due to carcinoma. Apparently therefore significant number of cases of primary carcinoma of the bronchus are being missed. Theoretically,

TABLE 1

DEATHS FROM CANCER OF BRONCHUS, LUNG AND PLEURA AS COMPARED TO TOTAL CANCER DEATHS, ILLINOIS, 1940-47.

Year	Total Cancer Deaths	Deaths from Cancer of Bronchus Lung and Pleura	Per cent of Total
1940	11,310	581	5.0
1941	11,590	675	5.8
1942	11,815	741	6.2
1943	12,142	788	6.4
1944	12,482	853	6.6
1945	12,865	914	7.1
1946	12,909	972	7.5
1947	13,446	1080	8.0

a follow-up of chest findings suspicious of neoplasm as found in an x-ray survey for tuberculosis should help in bringing to light some of the chest malignancies that are being missed.

In order to satisfy ourselves as to the value or lack of value of the procedure we embarked on such a project in cooperation with the Division of Tuberculosis Control. This activity lasted from March to October 1948. By the end of this period we felt we had sufficient data for evaluation.

During the period mentioned above 162,731 chests were x-rayed. The group studied was primarily urban although there was a fair representation of the rural population. The locations were widely scattered in down state Illinois and were outside of Chicago.

In our series of almost 163,000 films 332 or 0.2% had findings suspicious of neoplasm. Of the group surveyed 57,171 were 45 years of age and over.

In the tuberculosis screening program when findings suspicious of neoplasm are noted they are reported to the physician named as the family physician by the person having the x-ray. When our study program began we were sent copies of the above-mentioned report. In order to stimulate interest in the follow-up of such cases we wrote the doctors concerned offering them the services of the State-aided cancer diagnostic clinics of which there are twenty-two. Attention was called to the fact that the diagnostic service was available without charge to patients in poor financial circumstances.

In November 1948 we sent 326 questionnaires to physicians to whom we had offered diagnostic service in the follow-up of suspected neoplasms of the chest. The questions asked were as follows:

1. What was your final diagnosis?
2. If the diagnosis was cancer please answer the following:
 A. How was the diagnosis established?
 B. Was the disease early or well advanced?
 C. What treatment was given?
 D. Is the patient still alive?

From the 326 questionnaires 250 (76%) replies were received. Of the replies 55 were nonproductive because twenty-four persons did not contact the physicians named, 16 would not cooperate in further study, and 15 were unknown by the physician named. This left 195 replies of an informative nature. The analysis of these is given in Table 2.

TABLE 2

CHEST SURVEY
ANALYSIS OF INFORMATIVE REPLIES

Chest essentially negative	45
Specific diagnosis not made	21
Miscellaneous pathology	18
Nonmalignant neoplasm	16
Healed tuberculosis	15
Bronchitis and/or bronchiectasis	14
Cardiac hypertrophy	12
Malignant neoplasm	11
Pulmonary fibrosis	10
Pleural thickening	7
Goitre	6
Arrested tuberculosis	6
Aortic aneurysm	4
Asthma	4
Enlarged hilar lymph node	4
Neurofibromatosis	2
	195

As noted in Table 2, there are 18 cases listed under miscellaneous pathology. A breakdown of these is given in Table 3. In Table 4 is found an analysis of nonmalignant neoplasms and in Table 5 an analysis of the malignant neoplasms.

TABLE 3

CHEST SURVEY
MISCELLANEOUS PATHOLOGY

Anthracosis
Silicosis
Empyema
Paraffin pack
Pneumoconiosis
Histoplasmosis
Lipoid pneumonia
Curvature of spine
Scar from old empyema
Pneumonia with effusion
Artificial breast on left side
Eventration of right diaphragm (2)
Eventration of left diaphragm
Postoperative x-ray burn of chest
Diverticulum or cyst of pericardium
Residuum of virus infection
Suppuration in left upper lobe (cause undetermined)

DISCUSSION

In the attempt to determine the presence of cancer in its early stages screening procedures

TABLE 4

CHEST SURVEY
NONMALIGNANT NEOPLASMS

Type not determined	7
Pulmonary cyst	4
Cyst of thymus	1
Parathyroid adenoma	1
Tuberculoma	1
Neurofibroma	1
*Ganglioneuroma	1
TOTAL	16

*Classified as nonmalignant because not otherwise stated.

have come into vogue. The cancer detection clinic has been an outgrowth of this idea. Available information would indicate that in cancer detection clinics one may expect to find cancer in 1.0 to 1.5% of those examined.[2, 3, & 4] With the development of the Papanicolaou technique[5] for the diagnosis of cancer of the uterus by the examination of vaginal secretions, the possibility of its use as a screening procedure received serious consideration. Evidence would indicate that by this method one might expect to find one case of uterine cancer among 200 to 500 women free from symtoms or 0.5 to 0.2%.[6] Sherman[7] reports x-ray screening of 1,576 patients 45 years of age and over for the detection of symptomless tumors of the stomach. There were 1399 satisfactory examinations and three tumors were discovered: myosarcoma of the lower esophagus, gastric carcinoma and gastric polyp.

It was inevitable of course that attention would be given to the use of chest x-rays as a means of screening out tumors of the chest. Several such studies are being made in the United States and preliminary reports should be forthcoming soon.

As seen in Table 6 the observed death rate in Illinois for bronchus, lung and pleura cancer for 1946 and 1947 was 34 per 100,000 in the age group 45 and over. In Table 7 we see that in the same age group 45 and over we found 11 cases for a rate of 19.2 per 100,000. We found no cases out of the 86 suspects for neoplasm under age 45. If we had received satisfactory reports on 240 patients instead of 141 and if the same case rate had existed for the 240 as for the 141 then we should have found 19 cases among those over 45 years of age for a rate of 33.2 per 100,000. As it was, our case finding effectiveness was only little better than 50 per cent.

When we begin to analyze the type of chest malignancy found as indicated in Table 5 we are faced with the obvious fact that from the point of view of preventing cancer deaths we accomplished nothing. As a matter of fact by the time our questionnaires were sent out in November 1948 six of the cases listed in Table 5 were dead.

TABLE 5

CHEST SURVEY

MALIGNANT NEOPLASMS

	AGE	SEX
Metastatic secondary to cancer of breast	64	Female
	59	Female
	60	Female
Metastatic secondary to hypernephroma	51	Male
Metastatic secondary to cancer of rectum	57	Male
Metastatic secondary to cancer of mandible	67	Male
Metastatic secondary to cancer of prostate	78	Male
Metastatic primary site unknown	61	Male
Carcinoma type undetermined (Refused treatment)	63	Male
Carcinoma probably bronchogenic (Operative death)	57	Male
Pancoast tumor	46	Male

TABLE 6

DEATHS AND AGE SPECIFIC DEATH RATES FOR BRONCHUS, LUNG AND PLEURA CANCER:

ILLINOIS, 1946 and 1947

YEAR	AGE OF DEATH					
	45 and over		45-64		65 and over	
	No.	Rate*	No.	Rate*	No.	Rate*
1946	894	35.5	527	31.3	307	47.7
1947	868	32.8	578	29.4	290	42.8
	POPULATION ESTIMATES USED					
1946	2,520,131		1,876,249		643,882	
1947	2,644,215		1,966,574		677,639	

*Per 100,000 estimated population

Unquestionably we can obtain a better return in our case finding program if the patients in question receive more thorough clinical workup and the physicians of such patients take more advantage of existing consultation service. According to Hopkins and Abbott[8] in every suspected case roentgenograms should be made in several positions, bronchoscopic examination done and cellular specimens obtained for pathological examination. They were able to find carcinoma in an entire series of 112 cases by taking x-rays in front, side and oblique positions. While it is true that we had no positive accomplishment in finding early primary bronchogenic carcinoma it is felt that the project should continue as part of the tuberculosis chest x-ray program since it entails no appreciable added expense and does stimulate the diagnostic acuity of the practicing physician when such suspected chest lesions are brought to his attention.

SUMMARY

1. In a survey for tuberculosis among 162,731 people by use of the 70mm. x-ray film 332 showed findings warranting further study to eliminate the possibility of malignancy. Questionnaires were sent out on 326 of these.

2. Of the group surveyed 57,171 were 45 years of age and over.

3. In the age group 45 and over we found 11 cases for a rate of 19.2 per 100,000.

4. We found no cases out of the 86 suspects for neoplasm under age 45.

TABLE 7

CASES AND AGE SPECIFIC CASE RATES FOR BRONCHUS, LUNG, AND PLEURA CANCER FOUND THROUGH T.B. X-RAY SURVEY, ILLINOIS, 1948

	AGE		
	45 Years and Over	45 Years-64 Years	65 Years and Over
Persons surveyed	57,171	46,457	10,714
Suspects for neoplasm	240	152	88
Suspect rate per 100,000 persons surveyed	419.8	327.2	821.4
Malignant cases found	11 Case rate* 19.2	9 Case rate* 19.4	2 Case rate* 18.7
Percentage of fully reported suspects found with neoplasm	7.8%	10.1%	3.8%
Maximum number of malignant cases which could have been found if all questions had been answered**	19 Case rate* 33.2	16 Case rate* 34.4	3 Case rate* 28.0

*Rate per 100,000 persons surveyed

**Method of computation 7.8% of 240 = 19

TABLE 8

CANCER DEATHS BY PLACE OF OCCURRENCE, SEX, RACE, AND AGE, ILLINOIS, 1946

International List No.	Cancer of	Sex-Race	Total	Under 10 Years	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	Over 90 Years	Unknown Age
		All Races	972		2	3	2		9	11	38	73	147	187	180	158	84	45	25	7		1
47 C, D, E	Bronchus, Lung and Pleura	Male white	732		1	2	1		4	5	25	53	111	152	155	120	57	29	13	3		1
		Female white	182		1	1	1		4	3	5	13	16	29	23	31	25	14	12	4		
		Male negro	44						1		6	6	17	4	2	4	2	2				
		Female negro	12							3	2	1	2	2		2						
		Male other	2										1			1						
47 C	Bronchus	All Races	323						3	1	15	27	57	74	58	49	25	9	5			
47 C	Bronchus	Male white	258						2	1	12	20	44	62	52	38	17	7	3			
47 C	Bronchus	Female white	38						1			4	2	9	5	7	6	2	2			
47 C	Bronchus	Male negro	24								2	3	11	2	1	3	2					
47 C	Bronchus	Female negro	3								1			1		1						
47 D	Lung	All Races	640		2	3	2		6	9	22	45	89	113	120	109	57	35	20	7		1
47 D	Lung	Male white	468		1	2	1		2	3	12	32	67	90	102	82	39	21	10	3		1
47 D	Lung	Female white	142		1	1	1		3	3	5	9	14	20	17	24	18	12	10	4		
47 D	Lung	Male negro	19						1		4	3	5	2	1	1		2				
47 D	Lung	Female negro	9							3	1	1	2	1		1						
47 D	Lung	Male other	2										1			1						
47 E	Pleura	All Races	9							1	1	1	1		2		2	1				
47 E	Pleura	Male white	6							1	1	1			1		1	1				
47 E	Pleura	Female white	2												1		1					
47 E	Pleura	Male negro	1										1									

5. Based on the follow-up reports of these suspected cases no early primary bronehogenic carcinoma was discovered.

6. Regardless of the negative results it is felt that the chest cancer case finding program should continue as part of the tuberculosis x-ray program because as follow-up and diagnostic techniques improve there should be more encouraging accomplishment.

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PROLONGED CORTISONE THERAPY

The administration of cortisone acetate to patients with rheumatoid arthritis usually produces prompt and often dramatic suppression of the disease manifestations. The effects of the hormone are not lasting, however, and after withdrawal relapse ensues. For sustained improvement in a chronic disease such as rheumatoid arthritis, it appears that cortisone must be given more or less continuously. This raises the question whether administration may be continued effectively and safely for long periods.

Seventy-six patients with rheumatoid arthritis were given cortisone in the hope that treatment could be continued uninterruptedly for extended periods. For various clinical reasons it was necessary to discontinue treatment in 16 of these before six months, but the remaining 60 patients received the hormone uninterruptedly for six to 15 months. By using initial large suppressive amounts, then gradually reducing the dosage and finally employing smaller maintenance doses, adequate degrees of rheumatic control were maintained in approximately two-thirds of the original 76 patients. The ability to sustain satisfactory improvement varied indirectly, in general, with the severity of the rheumatoid arthritis. The chief detriment to better results in the more severe cases was the intervention of adverse hormonal side effects which developed frequently when large or relatively large maintenance doses were required to support satisfactory improvement.

Unwanted signs of hormonal excess developed in 40 per cent of cases at some time during the course of treatment. Most of them were mild or transient and disappeared or lessened when the dose of cortisone was reduced, but when the dose was reduced the degree of improvement often declined also.

During prolonged cortisone therapy evidence of functional suppression of the adrenal cortices, as indicated by a decreased response of circulating eosinophils to exogenous ACTH, was present. The depression of cortical function was temporary, however. Whether irreversible damage may result when the drug is employed for longer periods cannot yet be answered. *Excerpt: Summary: Results of Long-Continued Cortisone Administration in Rheumatoid Arthritis, Edward W. Boland, M.D., and Nathan E. Headley, M.D., Los Angeles, Calif. M., June,* 1951.

CASE REPORTS



Association of Masculinizing Tumor of the Ovary and Pregnancy

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A graduate nurse, married three years, was first seen when she was four and one-half months pregnant. Her previous history was negative except that she had had hypochromic anemia which had responded well to iron therapy. Her menstrual history had always been irregular and she would be amenorrheic for as long as six to eight months. It was for this reason that she did not consult anyone earlier concerning this, her first pregnancy.

She had been examined three times over a period of four years because of her amenorrhea. Once, three years before she became pregnant, the right ovary was slightly enlarged but was not cystic. Upon examination four months later, no tumor could be felt on this side. On a pelvic examination a year previous to the time the tumor was discovered, both adnexae were normal.

On physical examination the patient was a bright, attractive young woman of twenty-seven. There was evidence of hirsutism which had been present for seven years, such as hair on the upper lip and also around the nipples, but this was not marked. There was also a male escutcheon. The general physical examination down to the pelvis was negative. Her basal metabolism was "minus one" and the electrocardiogram showed no evidence of any abnormality. Clinical pelvimetry showed the pelvis to tend toward the male type with a height of the symphysis of 6 cm., and a transverse of the outlet of 8 cm. On pelvic examination it was found that the uterus was enlarged to about four and one-half months of pregnancy. The cervix was pushed up behind the symphysis due to a firm mass in the cul-de-sac.

Fetal movements were noted about February 1st, which corresponded to the size of the uterus and her estimated date of confinement was June 15th. Blood pressure and urine were within normal limits and the Rh factor was positive. Quite marked hypochromic anemia was present

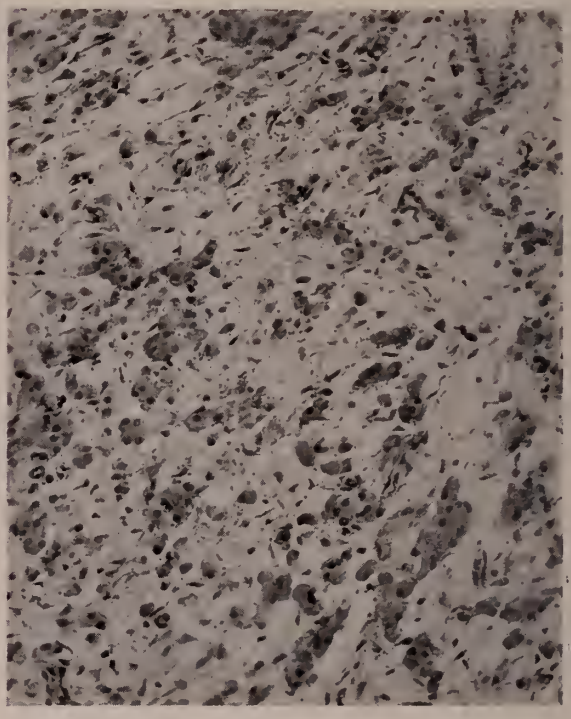
which responded well to anti-anemic therapy. On examination two weeks later the mass still remained in the cul-de-sac and the cervix was high behind the symphysis. She was referred to a roentgenologist for x-ray pelvimetry and also for a possible visualization of any osseous inclusions in the tumor mass. It was suspected that this might be a dermoid cyst. Pelvimetry done according to the Thoms-Torpin technique revealed a true obstetrical conjugate of 11.9 cm., a transverse diameter of the pelvic outlet of 12.8 cm., and a posterior sagittal diameter of the pelvic outlet of 4.8 cm. The pelvis was classified as the anthropoid type and was fully adequate for delivery. "The soft tissue mass which is palpable in the cul-de-sac does not show any osseous inclusions which would be expected in the case of dermoid cyst."

The patient pursued a normal prenatal course except that about one month later she developed evidence of slight toxemia with blood pressure of 150/90 and a trace of protein in the urine. This was treated by the usual methods. As pregnancy progressed the masculinizing features, which were only slightly apparent at the first examination, became more noticeable: the voice was becoming more husky and male-like, the hair on the upper lip and nipples increased, and the cheek bones appeared higher and the face more square than previously. There also was engorgement and increase in size of the clitoris. Very noticeable was a rather heavy, purplish acne of the sides of the face. As pregnancy continued these masculinizing features increased until at operation, she had an almost grotesque appearance, the voice was now almost guttural, the face had a square edematous look, there was hair along the sides of the face and on the upper lip, and the heavy acne on both sides of the face with the interspersed hair gave a complete loss of any appearance of femininity.

It was decided to operate upon her one month before the estimated date of confinement to remove the tumor. On May 17, 1948, through a midline incision, the abdomen was opened and the pelvis explored. The tumor was in the cul-de-sac, and adherent to the surrounding structures. It was freed by finger dissection and delivered into the wound, following which it was excised. The left ovary was normally enlarged for the state of pregnancy.

Gross examination of the ovary is reported as follows: "The specimen consists of an ovary with portion of attached tube. The ovary measures nine by eight by five centimeters. The capsule is slightly thickened. On section it is composed of a light gray, edematous, slightly translucent material with occasional cysts. This is a solid tumor of the ovary and has the general appearance of a fibroma.

"Microscopic study of the ovarian sections shows clumps and strands of large acidophilic polyhedral cells with distinct outlines and blue hyperchromatic nuclei. These clumps have no



distinct architecture. They lie in a loosely arranged fibrous stroma. There is much resemblance to adrenal cortical cells." The specimen was seen by several pathologists because of its rarity. Dr. Walter Schiller, who is recognized as one of the world's authorities on ovarian tumors, reported the section as follows: "The ovarian tumor consists of a loose stroma which contains specific cells ----. Morphologically these cells present the greatest similarity to Leydig cells especially to sympathicotropic cells ----. The tumor can be classified as diffuse sympathicoblastoma or diffuse Leydig cell tumor of benign character. The picture it offers has the

greatest similarity with virilizing tumors composed of sympathicotropic cells described by Berger. The fact that your tumor has virilizing effects on the patient supports this classification."

Pathological discussion: This tumor is usually unilateral, may develop in either ovary, varies from small size to fifteen centimeters in diameter, has a smooth contour and is smooth, firm, pale gray, encapsulated and when sectioned presents a bulging yellow and gray surface. It is nonmalignant in most instances though cases of deaths due to metastasis are on record. Some confusion exists concerning their diagnositic name. At present, it is preferable to designate them as "adrenal-like ovarian tumors".

The patient recovered from her operation and was discharged on the eighth day. While she was still in the hospital, her masculinizing characteristics decreased and continued to do so up to the time of her delivery, June 25th, thirty-nine days after the removal of the tumor. She had a normal spontaneous delivery of a living female child. Since it had been suggested that there might be a relationship between the original tumor and a hydatid mole, the placenta was examined microscopically and was normal. (At the age of ten months the child was examined and was normal except for slight obesity). The patient's postpartum course was entirely normal.

Following delivery, the patient continued to lose her masculine characteristics and to feminize. Three months later, she was again a pretty girl: her voice was natural and feminine, and the heavy broad features of her face receded. There was still a slight enlargement of the clitoris, but this was no more than it had been previous to pregnancy. From the fourth month on she menstruated regularly every twenty-eight days.

Conclusion: A case of pregnancy complicated by a masculinizing ovarian tumor is presented.

Tuberculous Appendicitis

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Primary tuberculosis of the appendix is very rare[1, 2, 3, 4], because of this rarity, a case is herein reported. The patient had no other foci of tuberculosis anywhere else in the body.

Secondary involvement of the gastrointestinal tract in patients with pulmonary tuberculosis is not rare.[5, 6, 7, 8, 9, 10] involvement of the ilcocecal region is found to be present in approximately 80% of people found to be dying with pulmonary tuberculosis, according to Brown and Sampson.[11] Chronic appendicitis is a term[13] which has come in much disrepute in recent years. The authors are not going to argue this point. However, we do believe that when the appendix is involved with a chronic type of infection such as tuberculosis, the term chronic appendicitis is applicable. According to Kornblith[14], the differential diagnosis of chronic appendicitis of a nonspecific character and of a chronic tuberculosis appendicitis is possible only after a histological examination of tissue removed at operation.

The initial symptoms of primary tuberculosis of the appendix are very indefinite.[15, 16] Symptoms at first are vague. There is a loss of appetite irritability of the gastrointestinal tract with nausea, possible vomiting and moderate loss of weight. The patient may have alternating attacks of diarrhea followed by constipation. After an apparently normal interval, this may recur. Later the diarrhea attacks become more frequent and are associated with a foul smelling, but seldom bloody stool. Colicky pains are also

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present in the lower half of the abdomen. The patient becomes anemic and emaciated. Physical examination reveals only slight tenderness on deep palpation in the lower right quadrant. X-ray of the gastrointestinal tract does not reveal anything specific. Spasticity with filling defects and hypermotility of the lower ileum, cecum, and ascending colon may be present.

In the differential diagnosis one has to consider simple, chronic, nonspecific appendicitis: All granulomas of the gastrointestinal tract; neoplasms of the gastrointestinal tract; and at times even peptic ulcers. The present case report shows the varied clinical pictures that primary tuberculosis of the appendix may present.

The present case is of a young, white, unmarried, female, 21 yrs. of age, born September 27th, 1927; hospital no. 256368. She has worked as a telephone operator and lived in Chicago all her life. She has never been on any farms. Patient states that over a period of a year and one half, especially when she was emotionally excited or under a nervous tension, she would feel nauseated and vomited. She did not seek treatment for this until March 1949. In March 1949, without any apparent cause the vomiting increased and began to occur after every meal. Occasionally, the patient would even awake at 2 or 3 in the morning from a deep sleep, and vomit. The vomitus usually consisted of undigested food and did not contain any blood or coffee ground material. Ordinarily, after the vomiting was completed, she would feel perfectly well. She continued this way until April 20th, 1949 when she noticed that her stools became black in color. However, she did not see a doctor until May, 1949. At this time a gastrointestinal x-ray series was done. A Roentgen diagnosis of a gastric ulcer was made. She was placed on a strict diet and given medication. On this regime she felt better, only for a period of 2 weeks.

About June 1st, 1949 her symptoms became more severe than ever. The vomiting now continued after every meal, and it was accompanied by a vague epigastric pain. There was no blood and no coffee ground material in this vomitus. The stools were a normal brown in color. Her weight had been dropping steadily and at this time it started to drop rapidly. From a high of 125 lbs. at the beginning of the year, she was now 89 pounds in weight.

The past history contains nothing specific. She had had the usual childhood diseases including measles, chickenpox and whooping cough. She had a tonsillectomy and adenoidectomy at the age of 10. Her menses started at 13 yrs. of age. They were regular every 28 days and she flowed for 5 to 7 days. The flow was not heavy and there was no dysmenorrhea.

The family history was essentially negative. There was no history of any tuberculosis, cancer or diabetes in any members of the family. There was no history of any tuberculosis in any immediate friend or relative. Her habits were moderate with no addiction to either alcohol or tobacco. An inventory of the systems was essentially negative except the gastrointestinal system which was as given above.

Physical examination revealed a very slight, young, white female, appearing chronically ill. The temperature was 98.6° orally. The pulse was 96. The blood pressure was 120/80. The physical examination was essentially negative except for the abdomen. The abdomen was scaphoid in appearance. The spinal column was easily palpable through the abdominal wall. No masses or rigidity were present. Liver, kidneys, and spleen were not palpable. There was a point of tenderness midway between the xiphoid process and the umbilicus about 1 inch to the right of the midline. There was also a point of tenderness at McBurney's point. Pelvic examination was essentially negative except for a point of tenderness on the right side in the right lower quadrant.

The laboratory findings were as follows: red blood count 4,930,000. Hemoglobin 11.8 gms or 75%. Color index 0.7 White blood count 13,650. Differential revealed neutrophils 69, lymphocytes 27, and monocytes 4. Wasserman test was negative. Total proteins were 6.5 gms. Blood albumin was 3.09 gms. and globulin was 3.14 gms. The urinalysis was positive for acetone. Sugar, albumin and diacetic acid were negative. There were a few epithelial cells and some calcium oxalate crystals present. Chest x-rays were negative.

On June 18, 1949 the patient was brought to surgery. Under general anesthesia a right rectus exploratory type of an incision was made in the right upper quadrant. The entire abdomen was explored. The liver, gall bladder, stomach and duodenum all were found to be normal. The

ascending colon, transverse colon, descending colon, jejunum, proximal ileum, sigmoid colon, rectum and entire pelvis were found to be all normal. The appendix was found to be enlarged: and measured approximately 1 inch in diameter by 4 inches in length. The serosa was granular and studded with numerous light grey, miliary nodules. There were many of these light grey miliary nodules also on the cecum and on the last two feet of the terminal ileum. There were a few of these light nodules on the peritoneum over the cecal area. The mesenteric glands were enlarged near the area of the terminal ileum. There were no signs of any bowel obstruction in any part of the intestine. After a thorough exploration of the entire abdomen, appendectomy was then done.

On section of the appendix the walls were found to be approximately ¼ inch in thickness. The lumen of the appendix was filled with a whitish, caseous material. Later, when microscopic sections were done, they revealed typical miliary tubercles with caseation and giant cell formation. The postoperative course was uneventful. The patient has had an improved feeling of well being ever since the operation. The anorexia, pain, discomfort, and tenderness in the abdomen have entirely disappeared. She has had marked gain in weight. Her present weight is 135 pounds. Similar results were reported by Henry C. Sweaney[17] upon using streptomycin for tuberculous enteritis.

We believe that in the present case the infection had its origin in the appendix, although this is difficult to prove without an autopsy. Subsequently, repeated x-rays of the chest, and repeated examinations of the entire body, have failed to reveal any other foci of tuberculosis.

SUMMARY

A case of apparent primary tuberculous appendicitis is presented. Microscopic section of the appendix proved the diagnosis. The patient became entirely well and is still well at this time. Thorough and repeated examination have failed to reveal tuberculosis anywhere else in the body. Dihydrostreptomycin was used and continued for four months after surgery in ½ grams doses twice a day.

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NEWS OF THE STATE



COOK

Society News.—"Parotid Gland Tumors" was the title of a talk delivered by Dr. Raymond W. McNealy before the American Society of Maxillofacial Surgeons, September 25. Dr. McNealy also addressed the Wisconsin Surgical Society, in Milwaukee, September 22, on "Carcinoma of the Colon."—The second annual scientific assembly of the Texas Academy of General Practice was addressed September 10-11, in Houston, by Dr. Philip Thorek on "Hand Infections" and "Intestinal Obstruction." Dr. Thorek also addressed the Iowa Academy of General Practice, in Des Moines, September 6, on "Modern Diagnosis and Treatment of Esophageal Lesions", and the Medical Assembly of West Tennessee, in Jackson, Tenn., September 4, on "The Pancreas and the Practitioner."

Personal.—Dr. Wayne B. Slaughter has been named head of the department of plastic surgery at St. Mary of Nazareth Hospital.

Dr. Percy Honored.—The Nelson M. Percy Research Foundation has been established at Augustana Hospital, honoring the hospital's chief of staff and head of its surgery department. Dr. Percy, who has been associated with Augustana Hospital for fifty years, is also senior attending surgeon at St. Mary's of Nazareth Hospital and professor emeritus of clinical surgery at the University of Illinois College of Medicine. The purpose of the foundation is "to perpetuate the name and memory of one of the masters of American surgery by adding to the sum total of medical knowledge through research and clinical investigations."

Physicians Honored.—Dr. Alfred S. Strauss recently received a scroll designating him as Alumnus Summa Laude Dignatus from the University of Washington in recognition of his accomplishments in stomach surgery. This is said to be one of the highest honors conferred by the university.—Dr. James P. Simonds, emeritus professor of pathology, Northwestern University Medical School, recently received an honorary degree of doctor of laws from Baylor University, Waco, Texas. The degree was presented on the fiftieth anniversary of Dr. Simond's graduation from Baylor.—A farewell dinner was given Dr. Agnes Sharp, director of research of the Psychiatric Institute of the Municipal Court, August 29. Dr. Sharp resigned from the institute after eighteen years to accept the post of superintendent of the volunteer program in state hospitals. Her new assignment was effective September 1.

New Officers.—Newly elected officers of the Chicago Society of Allergy for 1951-1952 are Dr. Theron G. Randolph, president; Dr. Milton M. Mosko, president-elect; Dr. Abe L. Aaronson, secretary-treasurer; Dr. Morris A. Kaplan, program chairman; and Dr. Leon Unger and Dr. Michael Zeller, public relations committee.

University News.—A grant of $2,100 has been received by the Chicago Medical School from the Lasdon Foundation Inc., of Yonkers, N. Y., according to an announcement by President John J. Sheinin. The grant is to be used for studies of fungus infections under the direction of Dr. David M. Cohen, professor of dermatology and syphilology.

Grant Supports Research on Leukemia.—A fight for the lives of thousands of children who die each year from leukemia, a cancer-like disease involving

the organs which make blood, is being waged at the University of Illinois College of Medicine in Chicago under a three-year grant from the Playtex Park Research Institute, it was announced September 6 by the University and the board of governors of the Institute. Playtex Park Research Institute is a non-profit, public service foundation devoted to supporting pediatric research. Dr. Harry A. Waisman will carry on the leukemic research. Dr. Waisman is a biochemist who has a doctorate in philosophy as well as in medicine.

The objective of his investigations in leukemia is to try to find out if there is a chemical basis underlying the abnormal white blood cell development that is characteristic of the disease. After a lead is found in this direction, the information may be projected for the treatment of the disease, very much like that which has been done in the use of liver or liver extracts, folic acid and vitamin B_{12} for pernicious anemia. His work is being based on recent evidence indicating that acute leukemia may be due to some chemical deviation from normal which permits white blood cells to develop in an abnormal manner. By finding out more about the chemical abnormalities of cell formation and growth, it is hoped that a more rational approach to treatment of the disease may be obtained.

Dr. Alving Studies Curative Value of Primaquine.—Dr. Alf S. Alving, professor of medicine in the University of Chicago School of Medicine, is flying to Tokyo to direct an Army confirmatory test of the curative value of the anti-malaria drug primaquine on returning Korean veterans, it was announced August 26. Primaquine, newly developed synthetic, was extensively tested on volunteer prisoners at Statesville (Illinois) penitentiary by Doctor Alving in a program made possible by the cooperation of Warden Joseph Ragen. In this and subsequent tests, the drug was highly effective as a malaria cure. Korea is an endemic area for malaria, and though the Army has been successful in keeping it in control with suppressive drugs, a considerable number of returned veterans have relapsed with malaria after the suppressive drugs have been withdrawn. Dr. Alving will direct administration of primaquine to veterans being rotated home, studying reactions to the drug, and will accompany a contingent so treated to the United States. He then will manage a follow-up study for the Army on the veterans who have received the drug.

Primaquine was the most valuable antimalarial drug discovered in an intensive effort in which more than 15,000 compounds were screened. Primaquine was synthesized by Robert C. Elderfield, professor of chemistry, Columbia University, and tested on animals by L. H. Schmidt of Christ Hospital, Cincinnati. The test on humans at Stateville produced practically 100 percent success in curing the disease.

KNOX

Summer Picnic.—The annual summer picnic of the Knox County Medical Society was held at the Soangetaha Country Club, July 25. The Fifty Year Club membership certificate and pin of the Illinois State Medical Society were presented to Dr. E. N. Nash, Galesburg. Officers of the Illinois State Medical Society in attendance at the presentation were Dr. C. Paul White, Kewanee, President; Dr. Harold M. Camp, Monmouth, Secretary; and Dr. Charles P. Blair, Monmouth, Chairman of the Council. Also present were Fifty Year Club members: Dr. E. C. Franing, Galesburg; Dr. Ernest E. Davis, Avon; and Dr. Ralph Graham, Monmouth.

MADISON

Society News.—The Madison County Medical Society was addressed September 6, in Edwardsville, by Dr. Harold M. Camp, Monmouth, Secretary, Mr. James C. Leary and Mr. John W. Neal, both Chicago, Director of Public Relations and General Counsel, Illinois State Medical Society, respectively. The speakers discussed "The Public Relations of Medicine."

ROCK ISLAND

Society News.—Dr. Armand J. Mauzey, Chicago, addressed the Rock Island County Medical Society, September 11, in East Moline, on "Sterility."

Personal.—Dr. William H. Otis, Moline, recently won the Illinois state and the National Rifle Association regional high power championships. Dr. Otis scored 610 points of a possible 650 aggregate in seven separate matches and he made Illinois rifle shooting history by being the first marksman to win The Tribune trophy with a perfect score since the trophy was donated in 1914. Dr. Otis also won this trophy in 1941 when his score was 98. In the recent match, Dr. Otis also won the Herald trophy with a perfect score of 50 for 10 shots, prone, at 600 yards, and the Wrigley trophy, for 10 shots standing at 200 yards, 10 shots prone at 600 yards, and 10 shots prone at 1,000 yards. His score was 145 of a possible 150 in this event.

SANGAMON

Society News.—Dr. George B. Bradburn, Chicago, discussed "Bleeding in Late Pregnancy and Postpartum Period" before the Sangamon County Medical Society in Springfield, September 6.

Society Officers.—The new officers of the Sangamon County Medical Society include Drs. Nelson H. Chesnut, president; Burle B. Madison, vice president; William De Hollander, secretary-treasurer; H. S. Dickerman Jr., and K. D. Kohlstedt, board of directors; Darrell H. Trumpe, and Kenneth Schnepp, delegates to the Illinois State Medical Society; and J. Marvin Salzman and Jacob E. Reisch, alternates.

ST. CLAIR

Society News.—Dr. William B. Raycraft, Oak Park, associate professor of pediatrics at Stritch School of Medicine of Loyola University, addressed a Maternal and Infant Welfare meeting sponsored by the St. Clair County Medical Society, October 4, on "Infant Feeding."

WINNEBAGO

Society News.—The Polio Committee of the Winnebago County Medical Society recently sponsored a special meeting and was addressed by Dr. Martin Seifert, Chicago, on "Successful Management of Bulbar Polio."

GENERAL

Town Begins Sodium Fluoride in Water Supply.—A valve was to be opened September 6 to admit sodium fluoride into the public water supply of the town of Assumption, making it the first Illinois community to begin permanent use of this chemical to prevent tooth decay among its children.

Approximately 50 cities in the state have shown interest in establishing this decay-preventing measure since it was advocated by the state health department and the Illinois State Dental Society this spring, but Assumption is the first where citizens approved its use with sanction of local dentists and approval of the health department.

Sodium fluoride has been added to the drinking water of Evanston for five years. This has been on an experimental basis, however, with the primary object being to study the effects of sodium fluoride rather than to prevent decay.

Scheduled to take part in the ceremonies accompanying the valve opening at Assumption were Dr. W. Philip Phair, Chicago, assistant secretary, American Dental Association; Dr. John Chrietzberg, of Springfield, chief of dental health of the state health department; Assumption city officials and a number of public health dentists from throughout the state.

Reduction in tooth decay of as much as 67 per cent has been found in communities where sodium fluoride has been added to water for as many as eight years.

In Evanston, children who were born the year the program was begun, five years ago, have suffered 50 per cent less tooth decay than would be expected in the absence of the protective measure.

George Wiltrakis Enters Private Practice.—Dr. George A. Wiltrakis, Saint Charles, left his position, which he held for the past six years, as deputy director, Illinois Department of Public Welfare, to devote his activities to the field of surgery. He will devote his time to private practice and serve as consulting surgeon to the various institutions of the department. Dr. Wiltrakis has been in the Illinois State Medical Service since 1930, being staff surgeon at Elgin State Hospital, assistant superintendent, Chicago State Hospital, and superintendent, Alton State Hospital and the Peoria State Hospital, prior to his position as deputy director.

Dr. Walter H. Baer, superintendent of Peoria State Hospital, Peoria, has been appointed acting deputy director, succeeding Dr. Wiltrakis.

Meeting of Military Surgeons.—The Association of Military Surgeons of the United States held its fifty-eighth annual convention at the Palmer House, Chicago, October 8-10. The program was presented to cover the following forums: Medical Manpower, Medical Experiences in Korea, Blood and Plasma, Hepatitis, Dysenteries, Thoracic Injuries, Vascular Injuries, Peripheral Nerve Injuries. Panels for allied services were conducted on dentistry, nursing, veterinary medicine, women's medical specialists corps and medical service corps. Among those in attendance at the session were Dr. H. Kenneth Scatliff, Dr. W. Randolph Lovelace II, Dr. James P. Hollers, Major General George Armstrong, Rear Admiral Lamont Pugh, Major General Harry G. Armstrong, Dr. Leonard A. Scheele, Vice Admiral Joel T. Boone, Colonel Robert C. Cook, Dr. Stanley Olson, and Edwin W. Baumann, D.D.S. Colonel Charles B. Puestow, M.C., A.U.S., chief of the surgical service at Veterans Administration Hospital, Hines, was general chairman.

College of Surgeons.—Twenty-six hospitals in San Francisco and East Bay communities and the medical schools of the University of California and Stanford University are planning clinics, demonstrations, postgraduate courses and other events for the surgeons and hospital personnel who attend the 37th Clinical Congress and the 30th Hospital Standardization Conference of the American College of Surgeons November 5 to 9 in San Francisco. Letterman Army Hospital surgeons are arranging a series of operative clinics which will be telecast, in color, to the Civic Auditorium. Extensive scientific and technical exhibits, registration, showings of medical motion picture films, clinics, hospital conferences, and a number of the official and scientific sessions will also be held in the Auditorium. The Forums on Fundamental Surgical Problems and some of the other sessions will be held in the Fairmont and Mark Hopkins hotels.

Dr. Henry W. Cave of New York, President of the American College of Surgeons, will preside at the General Assembly on the opening morning, when the subject of "Collaboration in Hospital Standardization" will be discussed by Dr. Arthur W. Allen, chairman of the Board of Regents of the College, by Dr. Anthony J. J. Rourke of San Francisco, President of the American Hospital Association, and by Dr. Dwight L. Wilbur of San Francisco, representing the American College of Physicians.

At the Presidential Meeting on the first evening, Dr. Alton Ochsner of New Orleans will be installed President.

HEALTH DEPARTMENT ACTIVITIES

Distribution of Biologic Preparations.—Enough biologic preparations to prevent more than one and a half million cases of illness were distributed by the Illinois Department of Public Health during the fiscal year ending June 30, 1951. Smallpox vaccine was distributed in the greatest quantity. Enough to protect more than 400,000 persons against this disease was provided by the health department during the 12 months. Sufficient diphtheria toxoid to immunize 325,000 persons and tetanus toxoid for protection of 315,000 were distributed during the same period. Whooping cough vaccine in sufficient quantity to immunize 240,000 children was dispatched from health department laboratories. Vaccines to protect 145,000 persons against typhoid fever and to prevent 3,426 cases of rabies were also distributed during the year. In addition to the immunizing preparations, the health department also provided enough silver nitrate to treat the eyes of every baby born in the state and a large volume of biologics for testing purposes. Tuberculin for testing 400,000 individuals for tuberculosis and Shick-testing material to determine susceptibility to diphtheria in more than 265,000 persons were provided. This entire program of biologic distribution cost $223,777, or about 2½ cents per person in Illinois.

The result?

Not a single case of smallpox during the year as compared to 10,928 cases 30 years ago when distribution of preventives was begun — diphtheria down from 16,764 cases in 1921 to 60 last year — a 66 per cent decrease in whooping cough.

DEATHS

Thomas L. Dagg, retired, Chicago, who graduated at the University of Michigan Medical School in 1898, died August 9, aged 83. He was attending pathologist at St. Luke's Hospital from 1903 until 1909, then became anesthetist there.

Nicholas Dykstra, Chicago, who graduated at Rush Medical College in 1920, died September 12, aged 59. A practicing physician here for 30 years, he was on the staff of Roseland Community Hospital.

Wade C. Harker, Chicago, who graduated at Stritch School of Medicine of Loyola University in 1919, died Sept. 8, aged 63. He was on the surgical staff of Garfield Park Community and Bethany Hospitals, consulting surgeon at Shriners' Hospital for Crippled Children, and Chief of Medinah Medical Staff. He was a councilor of the Illinois State Medical Society.

Lester MacLean, Chicago, who graduated at University of Minnesota Medical School in 1943, was accidentally drowned at Farm Island Lake near Aitken, Minn., July 6, aged 33. He was assistant professor of psychiatry at the University of Illinois College of Medicine.

James P. McGuire, Chicago, who graduated at Stritch School of Medicine of Loyola University in 1928, died Aug. 18, aged 47. He was on the staff of St. Francis Hospital, and in World War II was a major in the medical corps.

Edgar Stuart Mills, Chicago, who graduated at Rush Medical College in 1928, died June 4, aged 61. He was medical director of the Central Standard Life Insurance Company.

Louis D. Moorhead, Chicago, who graduated at Rush Medical College in 1917, died September 14, aged 58. He was senior attending surgeon at Mercy Hospital and formerly had been chief of staff there. From 1928 to 1940, he was dean and head of the department of surgery at Loyola University School of Medicine.

Frank Joseph Schick, Chicago, who graduated at University of Illinois College of Medicine in 1915, died in Kenora, Ont., Canada, July 2, aged 59.

Isadore S. Segall, Chicago, who graduated at University of Illinois College of Medicine in 1913, died August 10, aged 62. He was a member of the staffs of Walther Memorial, Chicago Physicians and Surgeons, and Kenner Hospitals.

Floyd W. Willis, Chicago, who graduated at Meharry Medical College, Tenn., in 1913, died August 17, aged 64. He was a member of the Provident Hospital staff for 30 years.

"FOR THE COMMON GOOD"

Health Talk on TV.—Since the last issue of the Illinois Medical Journal, the following telecasts have been presented by the Educational Committee over WGN-TV, Channel 9, on Tuesday evenings at 7:00 p.m.:

Noah D. Fabricant, August 28, Colds, Coughs and Complications.

Charles S. Gilbert, September 4, Why Be Fat?

Edwin S. Irons, September 11, The Antibiotics.

Lawrence W. Peterson, Allen Hrejsa, Irwin Dritz and Clarence G. Novak, September 18, Emergency Surgery. V. Mueller and Company Surgical Supplies, Ohio Chemical and Manufacturing Company, and Illinois Masonic Hospital provided equipment for this telecast.

E. William Immermann, September 25, Polio. Mercy and Children's Memorial Hospitals cooperated in making available equipment.

Your Doctor Speaks Over WFJL, Thursday evenings at 7:30 p.m., carried the following transcribed broadcasts under the auspices of the Educational Committee since the last issue of the Journal:

Edward G. Warnick, August 23, Atomic Medicine.

Charles H. Lawrence, August 30, Constipation.

Milton M. Mosko, September 6, Bronchial Asthma.

Harold R. Oberhill, September 13, Epilepsy.

William B. Serbin, September 20, Modern Obstetric Care.

Robert L. Schmitz, September 27, Stepping Stones in Surgery.

Lectures Arranged Through the Educational Committee:

Mary Ellen Reedy, Elmhurst, September 4, Lemont P.T.A., in Lemont, Understanding Our Children.

Lawrence Breslow, Chicago, September 24, Mothers' Club of St. Helen's School, Childhood Diseases.

Mrs. Kris Peterson, American Medical Association, Chicago, October 1, Woman's Auxiliary, North Shore Branch, Chicago Medical Society, Petticoat Public Relations.

Robert R. Mustell, Chicago, October 10, Adult Leisure Time Group, Hiram Kelly Library, Growing Old Gracefully.

Lectures Arranged Through the Scientific Service Committee:

Matthew Block, Chicago, September 13, Henry County Medical Society, in Kewanee, Radioactive Isotopes in Therapy, illustrated.

Lewis Woodruff, Joliet, September 18, Iroquois County Medical Society, in Watseka, Coronary Disease.

Harold W. Miller, Chicago, September 19, Du Page County Medical Society, Elmhurst, The Present Day Prenatal and Post-Natal Care of the Obstetric Patient.

Eugene A. Hamilton, Chicago, September 20, La Salle County Medical Society, in La Salle, Indications for Open Reductions of Fractures, illustrated.

George M. Cummins, Chicago, September 25, Medical Section of the National Fraternal Congress of America, Morrison Hotel, Chicago, The Ulcer Problem.

Herman F. Meyer, Chicago, October 18, Stock Yards Branch, Chicago Medical Society, A Practical Appraisal of Vitamin Supplements Available for Infants and Children, illustrated.

John J. Brosnan, Chicago, October 18, La Salle County Medical Society, Ottawa, Diseases of the Lung, illustrated.

Postgraduate Conference in Decatur.—A Postgraduate Conference arranged by the Postgraduate Education Committee in cooperation with the University of Illinois College of Medicine was held September 27 at the Orlando Hotel, Decatur, with the Macon County Medical Society acting as host. The following participated:

George A. Hellmuth, Chicago, Chairman, Postgraduate Education Committee, presiding.

Stanley Olson, Dean, University of Illinois College of Medicine, Introductory Remarks. Viewpoints of Medical Education of Interest to the General Practitioner.

Edmund Foley, professor of medicine, Differential Diagnosis of Jaundice, illustrated.

Max Samter, assistant professor of medicine, Has ACTH Changed Clinical Medicine?

Samuel G. Taylor III, associate clinical professor of medicine, Newer Therapeutic Principles in the Treatment of Advanced Carcinoma, illustrated.

LeRoy H. Sloan, clinical professor of medicine, Common Medical Neurologic Problems in General Practice.

Danely P. Slaughter, director of outpatient tumor clinic, Recent Advances in Fluid and Electrolyte Blance in Surgery.

James H. Mitchell, clinical professor of dermatology (Emeritus), Contact Dermatitis, illustrated.

A special feature of this postgraduate session was a Clinical Pathological Conference conducted by Granville Bennett, professor and head of the department of pathology, and Norman B. Roberg, clinical assistant professor of medicine.

Following the dinner, the evening session was presided by David F. Loewen, Decatur, president of the Macon County Medical Society. The speakers were Harold M. Camp, Monmouth, Secretary, Illinois State Medical Society, on You Too Have Responsibilities!, and Andrew C. Ivy, vice president in charge of the Chicago Professional Colleges, University of Illinois, on Applied Physiology of Biliary Tract.

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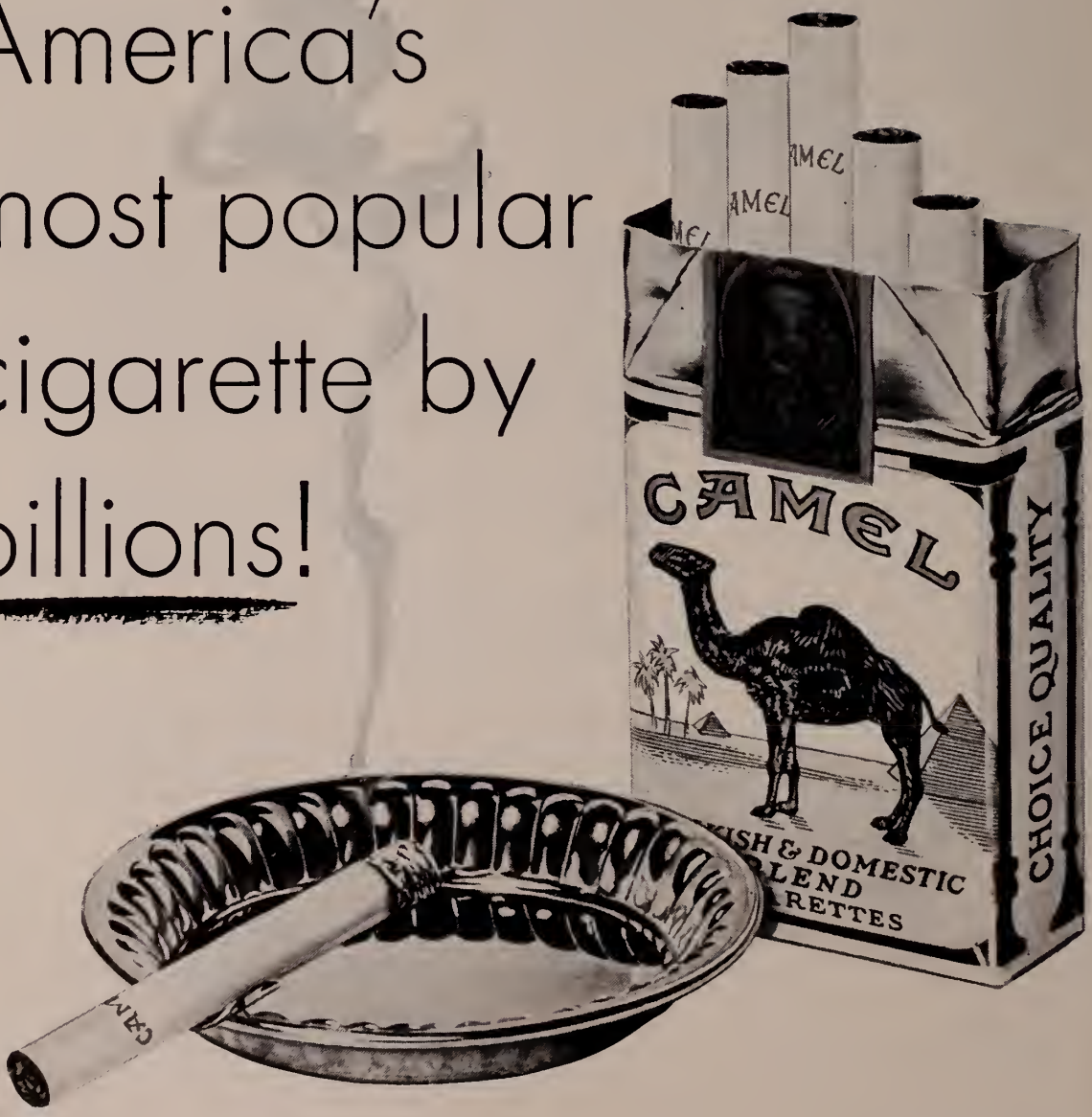
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Vice-President

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1. McLester, J. S.: Nutrition and Diet in Health and Disease, pp. 412-413, 1949.

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1. Clark, Le M.: The Vaginal Diaphragm. St. Louis, C. V. Masby Company, 1938; p. 43.
2. Dickinsan, R. L.: Techniques of Conception Control. Baltimore, Williams & Wilkins Company, 1950; p. 17.





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1. Long, C. F.: Indust. Med. 19:446 (September) 1950.

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Chemically Standardized Veratrum Viride Is Effective in Hypertension

Much has been written pro and con about the value of veratrum viride in hypertension. For many years the drug has been in disrepute because of the fact that the preparations available on the market have been prepared by "hit or miss" methods.

Chemical standardization of veratrum viride, however, has provided in this drug a highly effective agent for the treatment of hypertensive patients.

Sollmann[1] states that veratrum is probably the most active and reliable cardiac depressant and that its use serves to slow and soften the pulse and lower the blood pressure.

Willson & Smith[2] state that veratrum viride possesses a vasodilating effect and because of this, it was demonstrated by Hite,[3] and Freis and Stanton,[4] that the drug lowered pressure in hypertension and gave symptomatic relief. Recent research tends to show that the decrease in blood pressure results more from peripheral vasodilation than from depression of cardiac output.

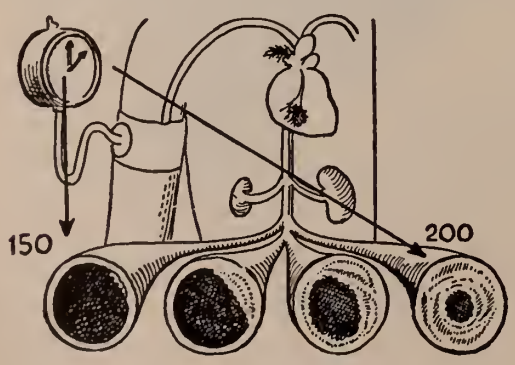
Uniformity of Action

When the veratrum alkaloids are chemically standardized, a uniform result can be expected. Their action usually causes a reflex fall in blood pressure and heart rate which originates in the afferent vagus nerve endings in the myocardium of the left ventricle and in the lungs. Although these factors ordinarily result with each heart beat, the veratrum alkaloids cause them to act continuously over prolonged periods of time. Reports have shown that 80 to 90 per cent of hypertensive patients respond to therapy when chemically standardized veratrum viride is used.

Cardio-Vascular Symptoms Cleared

In addition to the lowered pressure, objective signs of improvement may be observed, such as the clearing of retinal hemorrhages; diminution in cardiac size and reversal of left ventricular strain patterns in electrocardiograms.

Accompanying symptoms of the cardiac-hypertension syndrome, such as exertional dyspnea, tachycardia, nervous irritability, headache, are relieved. Yet, while the results of veratrum viride medication are prolonged, the drug may not afford quick relief.



Role of the Nitrites

For prompt and effective fall in blood pressure, nitroglycerin, which acts in one to two minutes, is the drug of choice. It acts rapidly and, because of its powerful vasodilatory action, gives the patient almost immediate relief. The action of nitroglycerin, however, is fleeting and to sustain lowered pressure between the action of nitroglycerin and veratrum viride, an intermediate is necessary.

To this end, sodium nitrite is used. This drug is also a vasodilator and affords sustaining relief until the long range action of chemically standardized veratrum viride becomes effective.

Importance of Sedation

Nearly all cases of hypertension require sedation for allaying periods of anxiety and affording the patient a good night's rest. Mild sedation is often useful, especially in cases associated with chronic coronary insufficiency.[5] It is well known that excitement may induce anginal attacks and in such cases, phenobarbital, because of its prolonged action, should be used.

All of these drugs, chemically standardized veratrum viride, nitroglycerin, sodium nitrite, and phenobarbital are to be found in Capsules RAY-TROTE IMPROVED, prepared by the Raymer Pharmacal Company of Philadelphia, Pa. Each capsule contains

Phenobarbital	15 mg.
Sodium Nitrite	30 mg.
Nitroglycerin	0.25 mg.
Veratrum Viride (standardized to 1.0% alkaloid content)	65 mg.

RAY-TROTE IMPROVED is effective in dosages of one capsule every three hours. It is contraindicated when renal insufficiency is present, or if pulse becomes abnormally slow following treatment.

For the 30% of hypertensive patients with capillary fault, the above formula, with 20 mg. of Rutin added, is available in RAY-TROTE with Rutin.

Bibliography

1. Sollmann: A Manual of Pharmacology, W. B. Saunders Co. (1942).
2. Willson & Smith: J. Pharmacol., 79:208 (1943).
3. Hite: Ill. M. J., 90:336 (1946).
4. Freis & Stanton: Am. Heart J., 36:723 (1948).
5. Falk: South. M. J., 40:501 (1947).

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PHYSICAL MEDICINE ABSTRACTS



EVALUATION AND PHYSICAL MEDICINE TREATMENT OF ARTERIOSCLEROTIC PERIPHERAL VASCULAR DISEASE

Bror. S. Troedsson, M. D. In JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION, 43:1:31, January 1951.

Arteriosclerosis is the number one disease of the present age and will become more so as the percentage of aged people increases. The disease may affect the arteries in all or in localized parts of the body. The heart, the kidneys, the brain and the lower extremities are the structures most frequently giving symptoms.

The treatment of peripheral arteriosclerotic vascular disease must have as its object a permanent increase of circulation to the extremity. To achieve this the problem must be attacked from two angles. The primary object is to try to increase the carrying capacity of the affected deeper vessels. The second object is to try to develop the carrying capacity of the collateral vessels, the arterioles and the capillaries. In physical medicine we have a number of agents that can be applied for these specific purposes and to specific areas without causing any undesirable side actions. Although there are hundreds of measures available, mention will be made only of the ones Troedsson uses most extensively.

If access to only one measure was possible, Troedsson would pick massage as the most important. Massage dilates capillaries and empties veins and thus permits secondarily easier inflow of arterial blood.

In trained and skilful hands massage can be directed to the affected arteries and used to stretch fibrous tissue in the vessels and possibly also break up early calcifications. Some of the effects of massage are better obtained by the use of mechanical apparatuses. The Sanders oscillating bed has a see-saw motion and in its upward tilt empties the venous bed of the lower extremities. In the downward tilt it promotes the influx of arterial blood. This bed has the advantage of being able to do it continuously for unlimited time. In the use of the Sander's bed, as well as the Buerger's exercises, we use the venous filling time to determine the time for dependency of the extremities and blanching time for period of elevation.

Besides the Sanders bed Troedsson has found the suction pressure boot, as developed by Herrman, of great value if properly understood and used. This apparatus, called the Pavaex, is used for its pumping action and the exercising action upon the capillary bed, an important phase of the treatment. Troedsson does not believe and has not found any clinical evidence that it affects the deeper arteries to any extent, though it may. The Pavaex apparatus must be used with great attention to detail and must be adjusted for each individual each time a treatment is given, so that a distinct flushing and blanching is produced with each cycle. This involves putting the extremities at the proper height, adjusting the pressures and the cycle, and adjusting the cuff pressure to where it barely prevents escape of air during the positive pressure phase. Unless this attention to details is carried out the results expected cannot be obtained and even harm may be done. It is Troedsson's conviction that the Pavaex should be used only in the hands of people who are willing and capable of giving it the detailed attention it needs. It is an apparatus to be mechanically applied, as has often been the case and which has detracted from its usefulness.

Practically every application of the Pavaex apparatus should be followed by "vascular massage" to the deeper vessels. The same applies to the whirlpool. This apparatus with its whirling, aerated, temperature

(*Continued on page* 58)



Two of these physicians suspected the worst...

but not until the significance and the incidence of amebiasis were thoroughly revealed at a hospital staff meeting. This meeting was held in a large city well north of the Mason-Dixon line, hardly a "tropical" climate, yet the incidence was high.*

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*Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.

adjusted water is very useful to create a hyperemia and to give a gentle massage at the same time. However, again it must be used only after a thorough evaluation of the circulatory capacity and generally only in the milder cases, followed by massage.

Physical medicine has many valuable agents, that can be specifically applied to specific areas in the treatment of arteriosclerotic peripheral vascular disease. Properly applied they are of more value than any medicinal agents in the treatment of uncomplicated peripheral arteriosclerotic vascular disease.

STUDIES ON INCREASED VASOMOTOR TONE IN THE LOWER EXTREMITIES FOLLOWING ANTERIOR POLIOMYELITIS

Frederic J. Kottke, M. D., Ph.D., and G. K. Stillwell, M. D., Minneapolis. In ARCHIVES OF PHYSICAL MEDICINE, 32:6:401, June 1951.

This study was carried out to determine effective methods of treating vasospasm of the lower extremities with the least inconvience to the patient. Procaine blocks were effective in causing vasodilatation of the extremities for a period of day or weeks. However, such treatment is not practical for prolonged periods because it requires frequent visits by the patient to the office of the physician. Both the dihydrogenated ergot alkaloids and Priscoline were found to be effective in aiding vasodilatation and obtaining relief from cold feet. Priscoline has certain undesirable side effects, especially production of nervousness and tremor which makes it undesirable in certain patients. C. C. K. (an equal mixture of dihydroergocornine, dihydroergocristine, and dihydroergokryptine) is milder and more prolonged in its action, but it appears to be an effective drug for most patients. It is the impression of Kottke and Stillwell that the combination of Priscoline and C. C. K. may be more effective than either drug by itself. Neither of these drugs completely blocks sympathetic activity. Such complete blocking of sympathetic activity would result in a hypotension which would incapacitate the patient during the period of the blockade. Mild interference with sympathetic activity by these drugs reduced the vasoconstricting response to cold and enhanced the vasodilatating response to heat, so that better circulation was maintained in the feet.

THE EFFECT OF A SHORT PERIOD OF STRENUOUS EXERCISE ON HEMOCONCENTRATION

Robert C. Darling, M. D., and Ethel Shea, B. A., New York. In ARCHIVES OF PHYSICAL MEDICINE, 32:6:392, June 1951.

A means of evaluating competence for physical exercise on an objective basis would be an important tool in studying convalescence, training, and rehabilitation procedures. Unfortunately, tests of "physical fitness" available at present all depend to some extent upon

(*Continued on page* 60)



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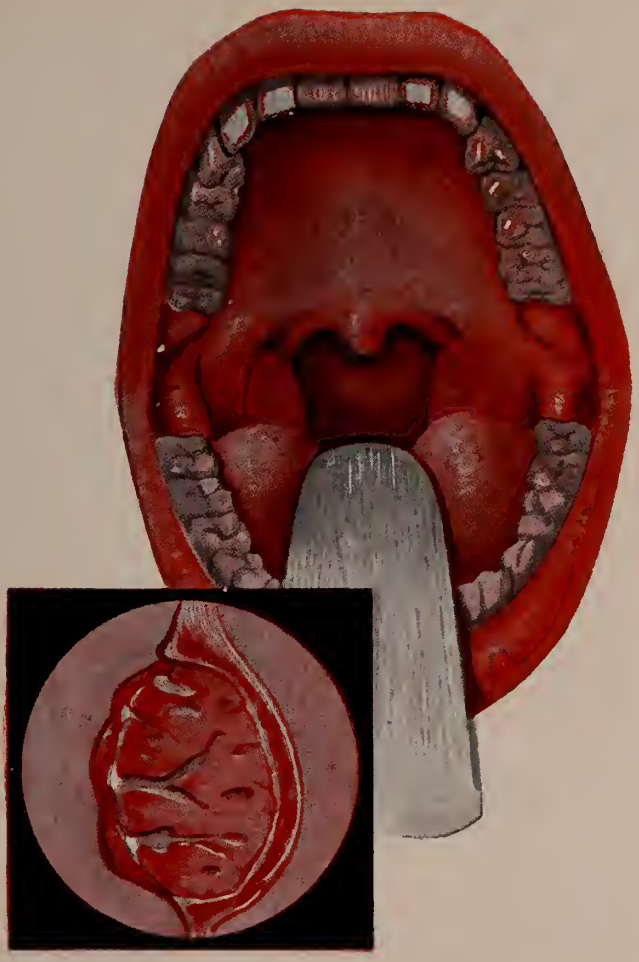
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Sayer, R. J.; Michel, J.; Moll, F. C., and Kirby, W. M. M.: Am. J. M. Sc. 221:256 (March) 1951

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 a. emphasis of patient's abilities not his disabilities
 b. participation in normal activities (not to the point of fatigue however)
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The drugs most commonly used at the present time are the barbiturates, the oxazolidinediones, and the hydantoins. Mesantoin is a newer hydantoin and is most effective in controlling grand mal, psychomotor and Jacksonian seizures.

DOSAGE REGULATION must be adjusted so as to obtain the smallest dose (usually 4-6 tablets) which will render the patient seizure free. Start therapy with ½ or 1 tablet daily. After a week on this dose a ½ or 1 tablet increment is added for one week. This is continued until the optimum maintenance dose is reached. If other medication is being taken unsuccessfully, Mesantoin can be added to the regimen in the same fashion, while the old drug is being reduced gradually.

SIDE EFFECTS—Mesantoin has been reported to produce side effects which can be manifested as a) rash b) drowsiness and c) blood dyscrasia. The skin and blood changes are primarily manifestations of individual sensitivity and indicate that the drug should either be reduced or discontinued.

PRECAUTIONS — as with most potent medication, certain precautions are necessary.

a. close check on the patient — repeated visits and blood counts — prescriptions should be non-renewable
b. no Mesantoin if original white blood count is below 4000
c. caution if rash or blood changes occur and if patient has history of previous skin rash or drug sensitivity
d. discontinue drug if bleeding of gums or vagina occurs — if patient develops sore throat or upper respiratory infections

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Physical Medicine (Continued)

emotional factors or upon the motivation of the subject to carry on an arduous piece of work. Therefore, they often fail to evaluate properly the physical component in "physical fitness" that we designate as physical competence.

Plasma volume has been observed regularly to decrease in response to a short period of exercise, but the amount of this hemoconcentration is quite variable from subject to subject and has not been correlated with other variables.

It seemed possible that if the water shift were a manifestation of some form of adaptation to exercise, the degree of hemoconcentration might bear a relationship to the ability to carry on exercise. Since hemoconcentration occurs with relatively mild exercise, a test depending on hemoconcentration might be devised which would be nearly independent of motivation of the subjects.

Two groups of subjects, one of trained athletes, the other or non-athletes were utilized in an attempt to relate the hemoconcentration of exercise to the physical component of physical fitness.

Utilizing serum protein and hematocrit as indices of changes in the plasma volume, Darling and Shea found the degree of hemoconcentration varied markedly among individuals in both groups and was unrelated in individuals to physical competence as judged by lactate rise and pulse rate acceleration during exercise.

ELECTROMYOGRAPHY IN THE EVALUATION OF THERAPEUTIC MEASURES

William Bierman, M. D., New York. In ARCHIVES OF PHYSICAL MEDICINE, 32:6:388, June 1951.

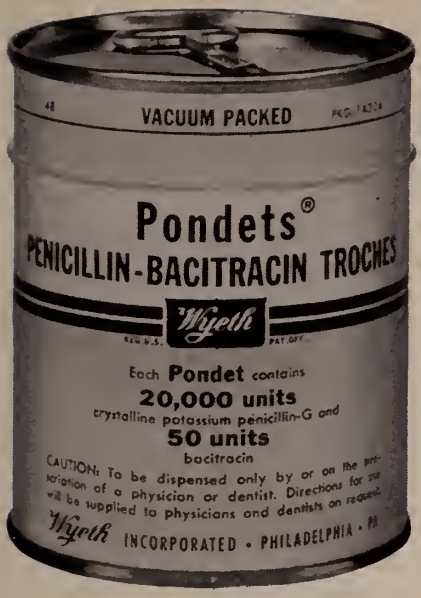
Information obtained by means of electromyography can be of quantitative value. It is a useful technic for the investigation of treatments advocated for neuromuscular disorders, and it permits a more exact study of kniesiology and a determination of the influence of blood flow on muscle action. Through its use, information can be secured which is of value in the administration of drugs, heat, cold, neurotripsy, manipulation, and occupational therapy, and of exercises applied actively, resistively, passively, synchronously, reciprocally, reflexly, or by reinforcement. It can be employed to study the phenomenon of fatigue. It is also reasonable to expect that it will be applied to evaluate other measures and that its diagnostic and research applications also will be extended.

"TENNIS THUMB": TENDINITIS WITH CALCIFICATION N FLEXOR POLLICIS LONGUS

Michael C. Oldfield, M.B.E., D.M., M.Ch., Oxfd., F.R.C.S. In THE LANCET, No. 6665, p. 1151, May 26, 1951.

Tendinitis with calcification, though commonest near

(*Continued on page 62*)



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1. Eagle, H., and Fleischman, R.: Proc. Soc. Exper. Biol. & Med. *68*:415, 1948

2. Bachman, M.C.: J. Clin. Invest. *28*:864, 1949

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Physical Medicine (Continued)

the insertion of the supraspinatus above the shoulder, probably can occur in almost any tendon and has been reported in the tendons around the elbow, wrist, hip, knee and foot (Lapidus 1943). No record has been found of calcification in the flexor pollicis longus, but Winchester and Mekie (1947) described calcification of the flexor carpi ulnaris near its insertion into the pisiform bone.

The most likely cause of the calcification is repeated friction or small strains. Single sudden sprains and septic infections, such as tonsillitis, have been suggested as occasional etiological factors.

Treatment in the acute stages is by rest and immobility. Massage and movement are harmful, but short-wave therapy may relieve pain. Open operation with incision of the tendon and evacuation of the gritty pultaceous material has been practised with success but seems unnecessary. Injection of 2 per cent procaine into the tendon may relieve pain if this is severe. Injection of local anesthetic solution and saline solution followed by aspiration has been used with success, and Sandstrom advised local rest combined with X-ray therapy.

Oldfield considers that complete rest, with plaster immobilization in the acute stages, is all that usually is necessary.

(*Continued on page 66*)

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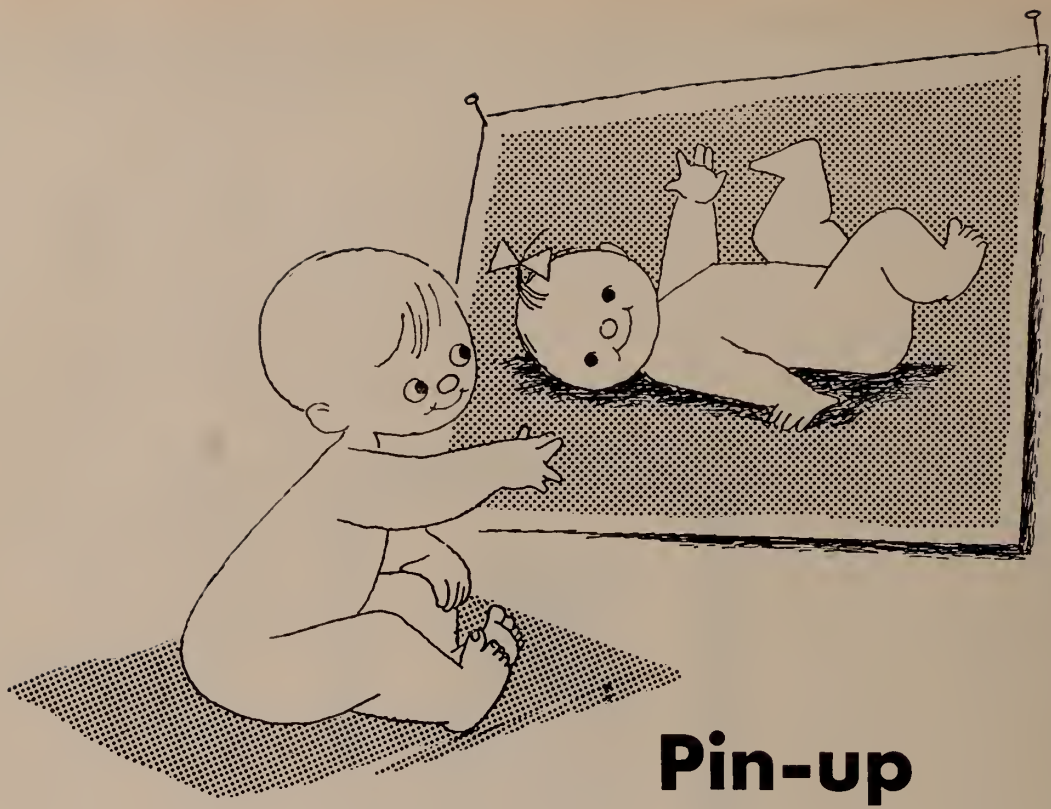
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Physical Medicine (Continued)

IONTOPHORESIS IN OPHTHALMOLOGY

Vernon L. Smith, M. D. In AMERICAN JOURNAL OF OPHTHALMOLOGY, 34:5 (Part I): 698, May 1951.

The treatment of ocular disease by iontophoresis has assumed increasing importance with the advent of chemotherapy and the antibiotics. Ion transfer of these drugs often serves to introduce them into the globe in concentrations greater than can be obtained by any other method short of actual inoculation.

The purpose of this paper is to review briefly the literature on the theory, technic, and clinical applications of ocular iontophoresis.

The use of iontophoresis for the introduction of certain drugs into the eye is based upon sound scientific principles.

The selection of the charge to be used at the active electrode varies with the drug employed. This charge must be the same as that of the ion which is to be introduced into the eye.

The apparatus required for ocular iontophoresis is both simple and inexpensive.

The technic of iontophoresis is easily carried out in the busy office or hospital in but a few minutes.

Ion transfer provides a method of introducing high concentrations of many useful drugs into the eye.

CHRONIC ARTHRITIS OF SENESCENCE

Russell L. Cecil, M. D. In GERIATRICS, 6:3:179, May-June 1951.

Senescence inevitably brings with it various ailments and disabilities, one of the commonest of which is some form of arthritis or rheumatism. These forms are discussed as to their effect on the aging patient. Phyical therapy is recommended as an adjunct in the treatment of these conditions.

Throughout the years, there has been a definite line of separation between the functions of the hospital and those of the health department. Health departments accepted the responsibility for the control of communicable disease within the community while hospitals confined themselves to the diagnosis and treatment of disease of patients within the institution. In recent years, there has been an awakening to the fact that these traditional functions must be broadened and integrated if the maximum benefit to the health of the nation is to be achieved. In the field of tuberculosis control, this coordination of activities is essential. The hospitalization of the tuberculous patient is but one phase of the total care. The hospitalization cannot be carried out most effectively without relationship to what precedes and follows in the life of the patient. Pub. Health Nursing, Elva M. Lewis, R.N., August, 1950.



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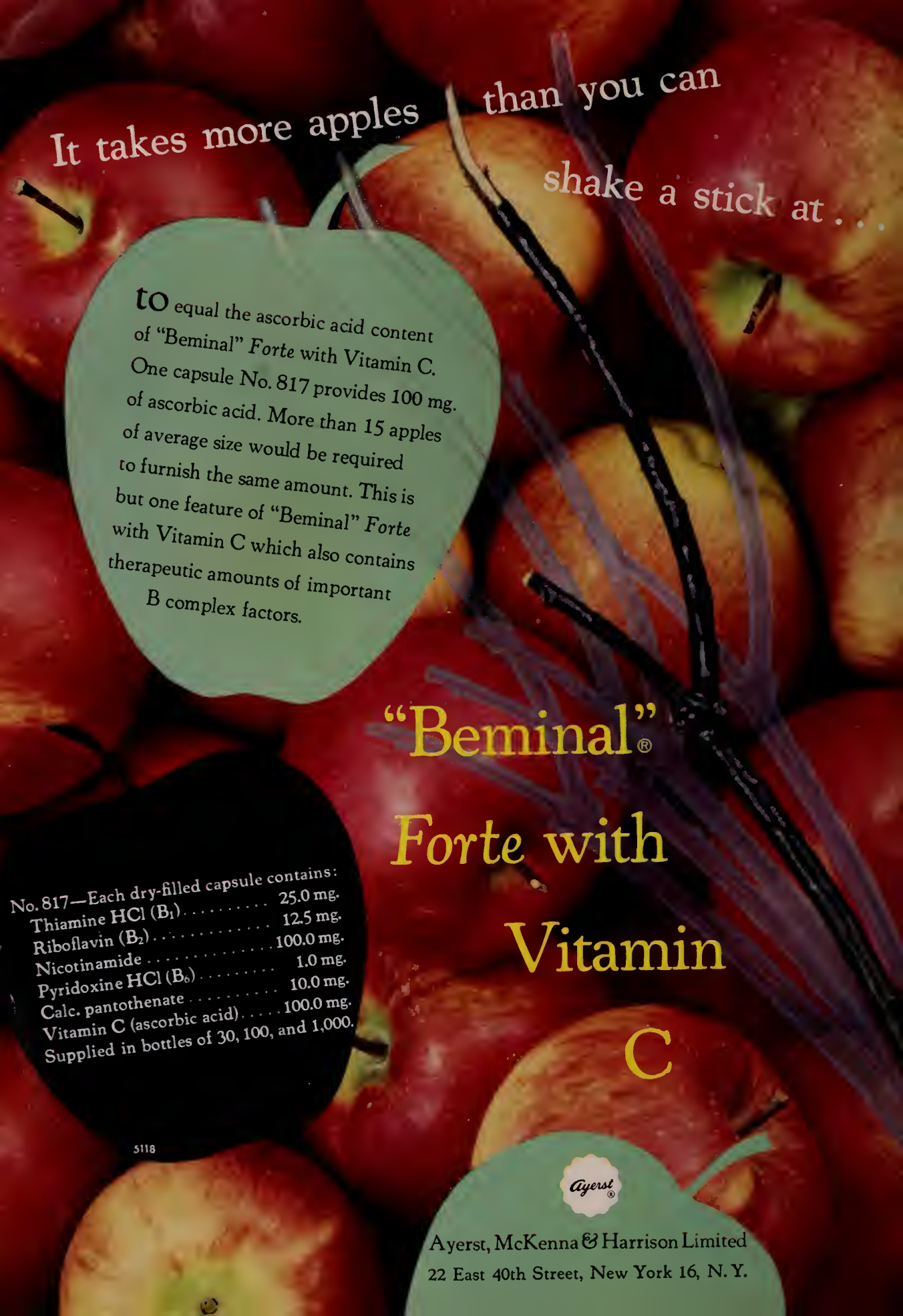
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BOOK REVIEWS



A Handbook on Diseases of Children, including Dietetics & the Comon fevers. By Bruce Williamson, M.D. Edin., F.R.C.P. Lond. Sixth Edition 440 pages, 94 illustrations, 9 in color. The Williams and Wilkins Company, Baltimore, 1951.

This little handbook, attractively bound in soft black imitation leather, was evidently written for the assistance of the busy practitioner, who, overwhelmed by the necessity of filling out endless official reports, must of necessity have a source of condensed information, readily and quickly available, to aid him in his professional work. Although dated the current year, much of its material borders on the obsolete. For example, in discussing the treatment of epilepsy, no drug more recent than diphenyl hydantoinate is mentioned, and yet, in the formulary just preceding the index, there is a brief description of the more commonly used antibiotics, including neomycin and polymyxin. Clinical descriptions are succinct; therapeutic recommendations generally vague. The book was made and printed in Great Britain (Edinburgh) on glossy paper; the type and format are pleasing and easy to read; the illustrations leave much to be desired. It deserves a place in the library of anyone who is interested in pediatric medicine as is practiced in the British Isles.

J. C. M.

Child Psychiatry in the Community. A Primer for Teachers, Nurses, and Others who care for Children by Harold A. Greenberg, M.D. in collaboration with Julius H. Pathman, Ph.D., Helen A. Sutton, R.N., B.A., B.S. and Marjorie M. Browne, B.A., M.A. 296 pages. G. B. Putnam's Sons, New York, 1950.

This interesting and well-written book, while not primarily intended for the practitioner of medicine, should certainly be read by anyone who treats children and tries to develop an insight into problems peculiar to that age. These problems are not always medical but are frequently brought to the doctor's attention in an oblique manner by the parents because they do not know to whom else to turn. The theme of the book is an explanation of and a strong argument for the Child Guidance movement which began in the twenties and is now spreading widely over the country. The material is divided into three sections: Section I, "The Child" presents a history of the child-guidance movement, followed by a discussion of the development of personality, the psychogenesis of behavior problems, diagnostic conditions, and an introductory section on treatment. Section II, "The Clinic Team" describes the functions and specific duties of the psychiatrist, psychologist and social worker. Section III "The Clinic and the Community discusses the functioning of the clinic team individually and as a group in the community. Numerous case reports serve to emphasize as well as to explain clinic function. The book closes with a glance at the future leaving the reader with the conviction that the only real solution to the complex problem of child-guidance lies in the establishment of more clinics, where really desired by the community, and staffed by even more thoroughly trained personnel.

J. C. M.

A History of Neurological Surgery Edited by A. Earl Walker, M.D. Williams & Wilkins Co. Baltimore, 1951.

This monograph on A History of Neurological Surgery and its origin in the Division of Neurological Surgery of Johns Hopkins University. During the winter of 1949-50, the members of the Division of Neurological Surgery of the Johns Hopkins University,

(*Continued on page 72*)

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BOOK REVIEWS (Continued)

presented in seminars the history of the development of the surgery of the nervous system. The subject proved so fascinating that the speakers resolved to collect and publish the essays presented. Although the following chapters are elaborated versions of the seminar presentations, the general outline of the papers has been followed thus giving birth to the history of Neurological Surgery in 1951. The authors, of the various chapters, in order to prevent false or inaccurate concepts, have consulted freely with more mature minds in the field of the history of medicine and neurological surgery. There are 18 chapters and 583 printed pages with many authentic old prints and illustrations. There are 2371 references in the bibliography, thus making this monograph a necessity in the library of every physician and surgeon. Certainly, this monograph is a must for every medical man interested in the diseases of the nervous system. The editor of this volume has done a tremendous job and has made it extremely easy for anyone interested in the early aspects of neurology and neurological surgery.

T. T. S.

Practical Clinical Psychiatry Edward A. Strecker, Litt. D., LL.D., M.D. Franklin G. Ebaugh, M.D. Jack R Ewalt, M.D. Section on "Psychopathologic Problems of Childhood" Leo Kanner, M.D. 7th Edition. The Blakiston Co. 1951.

This is the seventh edition of "Clinical Psychiatry" authored by men who have had considerable clinical experience in affections of the mind and brain. It is a text book used in many medical schools for the junior or senior medical students. The authors are fully conscious regarding the large number of sick people needing the care of psychiatrists. Unfortunately, with more than 5,000,000 patients ill with psychoneuroses and related affections, it becomes quickly evident that there is a considerable shortage of properly trained psychiatrists. To overcome this it will be necessary for all of us to try to convince more of the medical students to go into psychiatry. As one of the authors stated (Strecker) "A near miracle has been wrought, but the need is so great that what has been done thus far is merely a drop in the bucket", albeit a big and important drop. The need for properly trained psychiatrists to care for the mentally sick will require many years of teaching and training.

The authors have tried to get out of psychoanalysis a considerable amount of practical application in the teaching of clinical psychiatry. In other words a real attempt is made in this book to discuss and describe clinical psychiatry in the most simple way so that the average student will understand motivations of conduct and behavior. Certainly, this is one of the methods of getting the medical student interested in psychiatry. There are fifteen chapters and 469 pages of easy reading of excellent discussions of mental diseases. The first edition of "Clinical Psychiatry" was published in

(*Continued on page* 74)



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1. Hoffman, Murray M., Ill. Dent. Jl., 19:439 445 (Oct., 1950)

2. McNealy, Raymond W., Ill. Med. Jl., 97:150 (Mar., 1950)

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BOOK REVIEWS (Continued)

1925: this seventh edition appears now in 1951, thus making seven editions in 26 years. The authors feel that such a situation as above has made them fully conscious of its need plus an appreciation of pride and humility. They earnestly hope that they shall continue to merit the confidence of the medical profession. The reviewer feels that this book on clinical psychiatry should be in the hands of every physician.

T. T. S.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

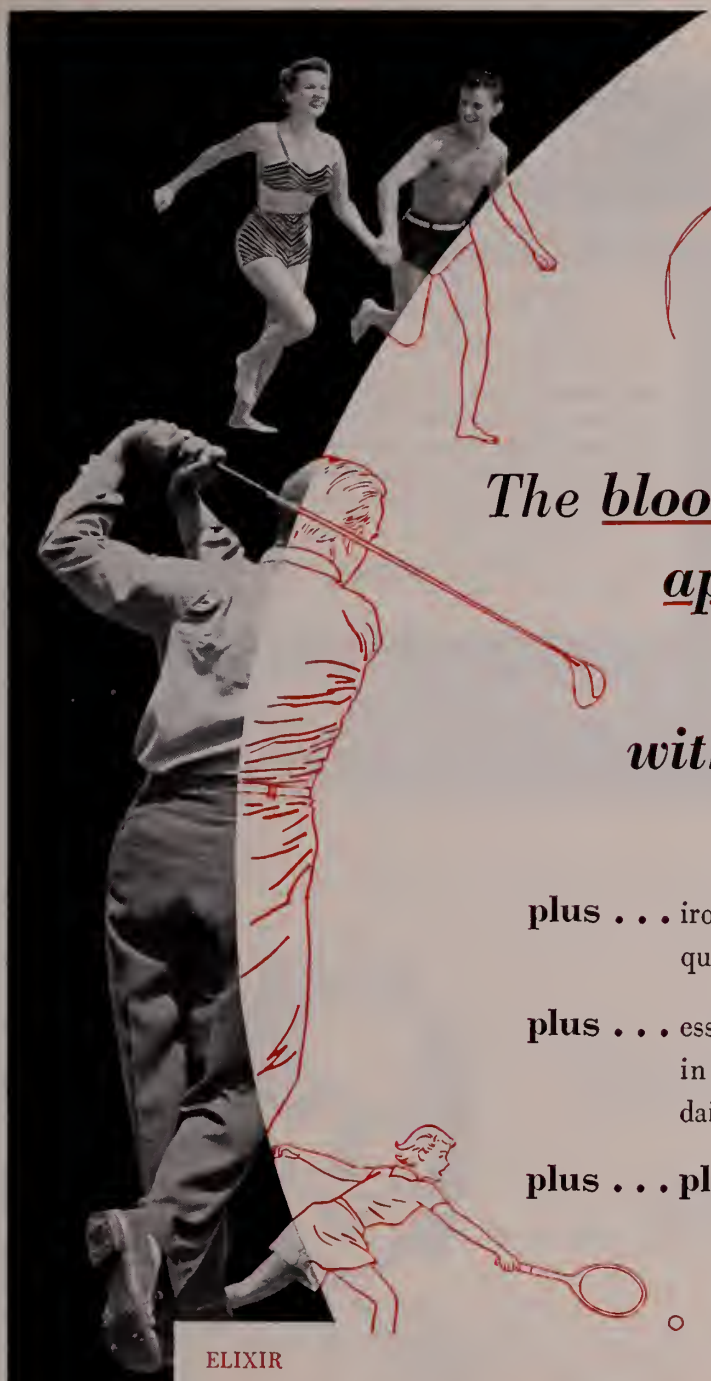
Obstetrical Practice. By Alfred C. Beck, M.D., Professor Emeritus of Obstetrics and Gynecology, State University of New York, College of Medicine at New York City; Formerly Professor of Obstetrics and Gynecology, Long Island College of Medicine; Formerly Obstetrician and Gynecologist-in-Chief, Long Island College Hospital; Consultant in Obstetrics and Gynecology, Long Island College Hospital and Norwegian Hospital, Brooklyn, New York, U. S. Naval Hospital, St. Albans, N. Y., Vassar Brothers Hospital and St. Francis Hospital, Poughkeepsie, N. Y. The Williams & Wilkins Company, Baltimore. Fifth Edition. $10.00.

Incontinence in Old People. By John C. Brocklehurst, M.D., Major, R.A.M.C. Formerly Christine Hansen Research Fellow in the University of Glasgow. With a foreword by Stanley Alstead, M.D., F.R.C.P., Regius Professor of Materia Medica and Therapeutics, University of Glasgow. E. & S. Livingstone Ltd., 17 & 17 Teviot Place, Edinburgh, 1951. $6.50.

The Early Diagnosis of the Acute Abdomen. By Zachary Cope, B.A., M.D., M.S., Lond., F.R.C.S. Eng., Consulting Surgeon to St. Mary's Hospital, Paddington, and to the Bolingbroke Hospital, Wandsworth Common; Late Hunterian Professor, Arris and Gale and Bradshaw Lecturer, Royal College of Surgeons; tenth edition. Oxford University Press, London, New York, Toronto, 1951. $3.50.

The Architecture of Normal and Malformed Hearts; A Phylogenetic Theory of Their Development. By Dr. Alexander Spitzer, Late professor of Anatomy, the University of Vienna. With a summary and analysis of the theory by Maurice Lev, B.S., M.D., Associate Professor of Pathology, University of Illinois College of Medicine, Associate Pathologist, University of Illinois Hospitals, Chicago, Illinois, and Aloysius Vass, M.D., with a foreword by Otto Saphir, M.D., Pathologist, Michael Reese Hospital, Clinical Professor of Pathology, University

(*Continued on page* 78)



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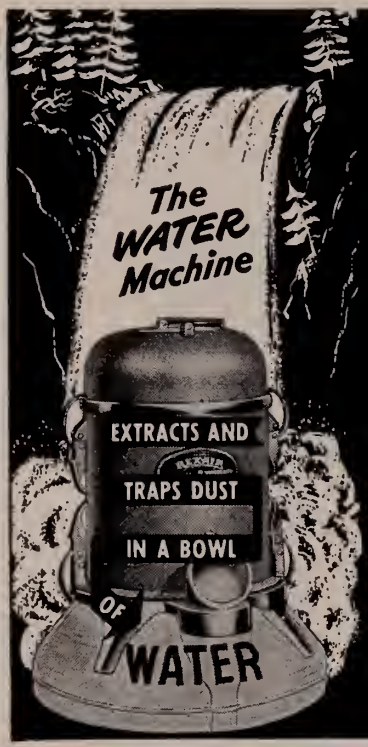
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of Illinois College of Medicine, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois, 1951. $5.00.

DIABETES CONTROL. By Edward L. Bortz, M.D., Chief of Medical Service B., The Lankenau Hospital; Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia. Former President of the American Medical Association. Illustrated. Lea & Febiger, Philadelphia, 1951. $3.50.

LET'S HAVE HEALTHY CHILDREN. By Adelle Davis, A.B., M.S., Consulting Nutritionist. Harcourt, Brace and Company: New York. $3.00.

ALLERGY IN RELATION TO PEDIATRICS. By Bret Ratner, M.D., Professor of Clinical Pediatrics (Allergy) and Associate Professor of Immunology, New York Medical College; Attending Pediatrician, Flower and Fifth Avenue Hospitals; Director of Pediatrics, Sea View Hospital. An official publication of The American College of Allergists. Bruce Publishing Company, Saint Paul and Minneapolis, 1951. $3.75.

BACKACHE, Birth and Figure Relief by Self-Revolving Hipbones. By William Schoenau. Published by William Schoenau, Los Angeles, California. $2.00.

BACTERIAL AND VIRUS DISEASES: Antisera, Toxoids Vaccines and Tuberculins in Prophylaxis and Treatment. By H. J. Parish, M.D., F.R.C.P.E., D.P.H., Clinical Research Director, Wellcome Foundation

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Ltd.; formerly Bacteriologist, Wellcome Research Laboratories; Second Edition; The Williams and Wilkins Company, Baltimore, 1951; $2.50.

THE CHANGING YEARS: What To Do About the Menopause. By Madeline Gray. Doubleday & Company Inc. Garden City, New York, 1951. $2.75.

FROM DUGOUT TO HILLTOP: By Margaret R. Stewart, M.D., Murray & Gee, Inc. Culver City, Calif. 1951. $3.75.

THE ESSENTIALS OF MODERN SURGERY. Edited by R. M. Handfield-Jones, M.C., M.S., F.R.C.S. Senior Surgeon to St. Mary's Hospital; Lecturer in Surgery, St. Mary's Hospital, Medical Members of the Court of Examiners, R.C.S., and Examiner in Surgery to the University of London; Late Hunterian Professor, R.C.S., and Sir Arthur E. Porritt, K.C.M.G., C.B.E., M.A., M.Ch., F.R.C.S., A surgeon to his Majesty the King; Surgeon, St. Mary's Hospital and Royal Masonic Hospital; Consulting Surgeon, Acton, North Herts and South Beds, Teddington, Hampton Wick and District, and Paddington (I. C. C.) Hospitals; Examiner in Surgery, University of Cambridge. Fourth Edition. With 644 illustrations of which many are in colour. The Williams and Wilkins Company, Baltimore, 1951. $11.00.

A TEXT-BOOK OF MEDICINE. Edited by E. Noble Chamberlain. With 266 illustrations; a number in colour. The Williams and Wilkins Company, Baltimore, 1951. $10.00.

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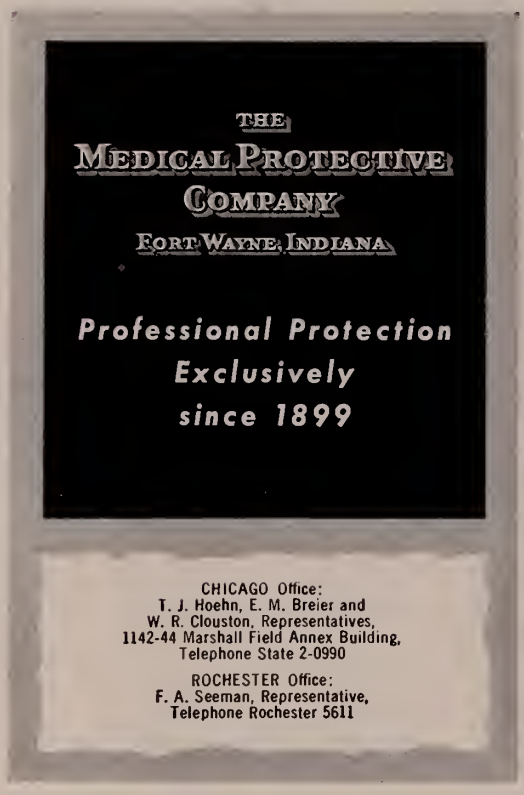
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The necessity of professional consideration of the personal problems of tuberculosis patients has become generally recognized as an essential part of their treatment and as a means of preventing them from leaving the hospital against medical advice. G. Canby Robinson, M.D., Bull. Johns Hopkins Hosp. April, 1951.

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November, 1951

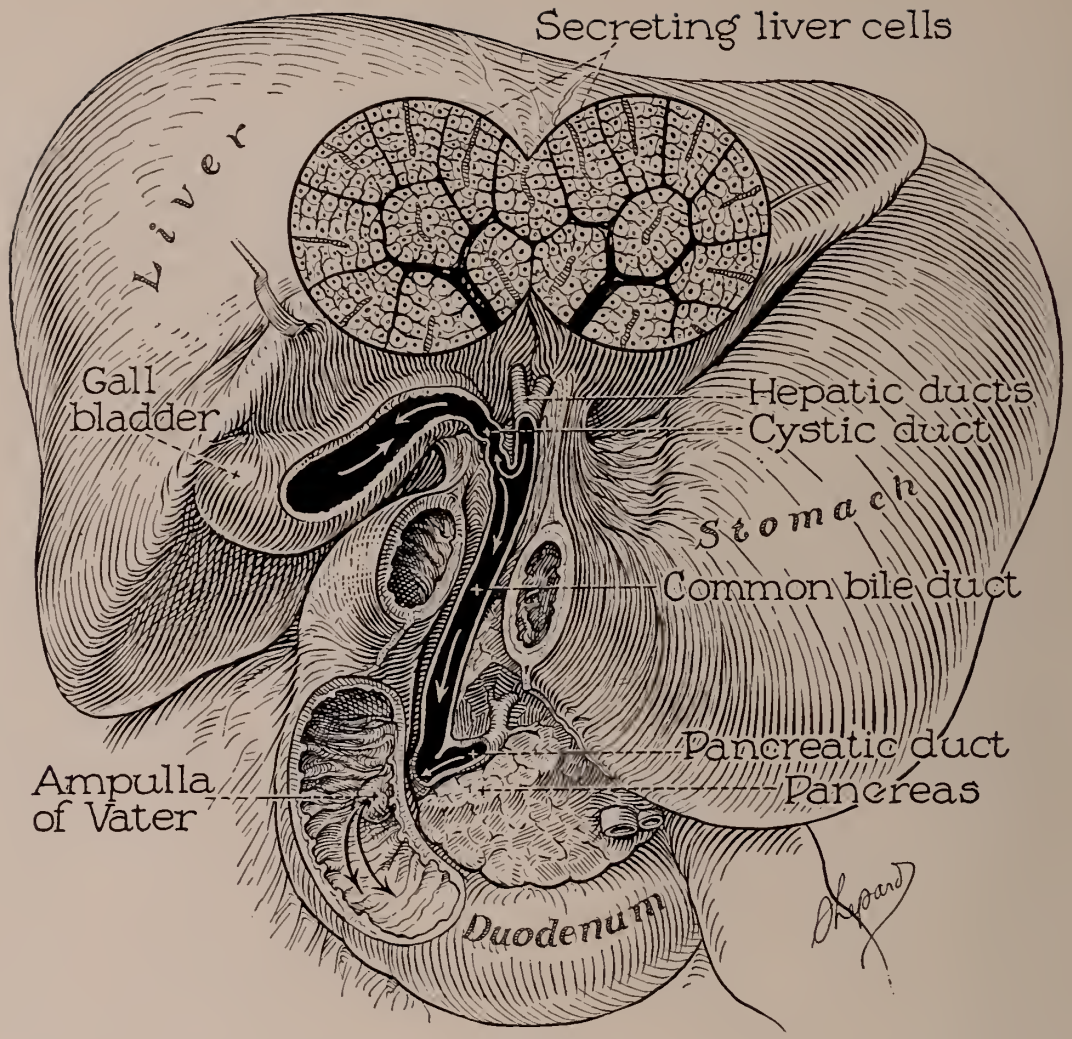
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(See page 5 for Table of Contents)

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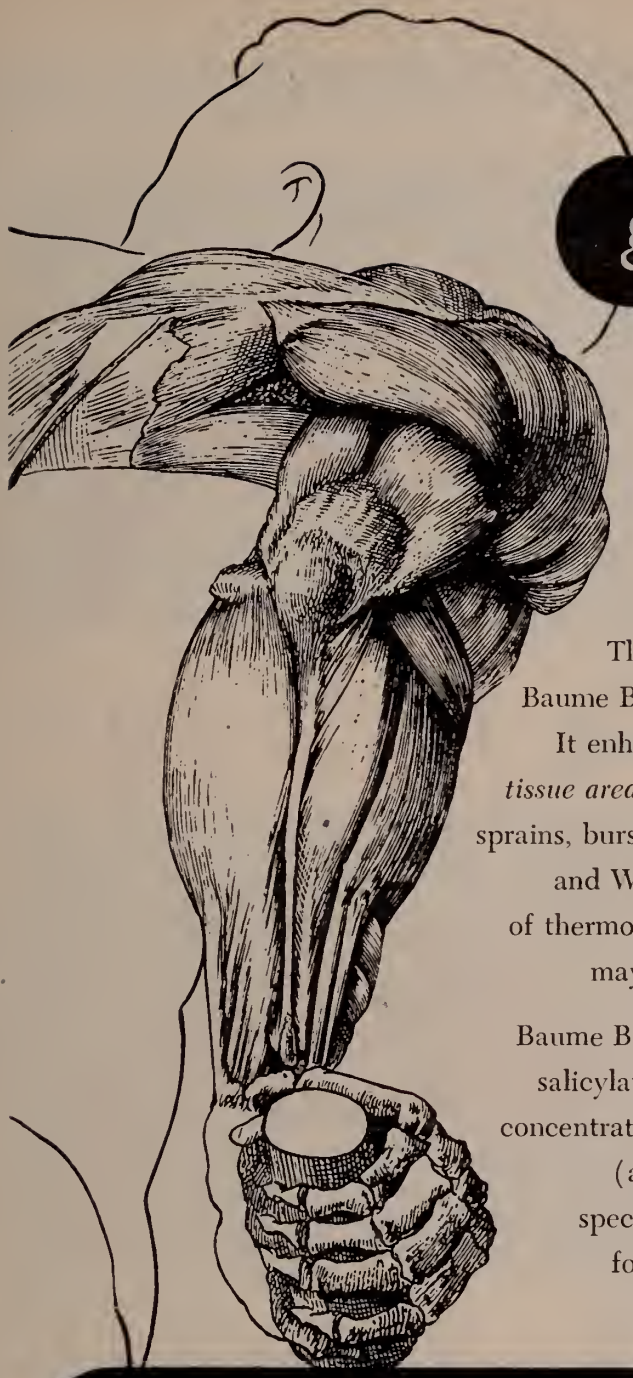
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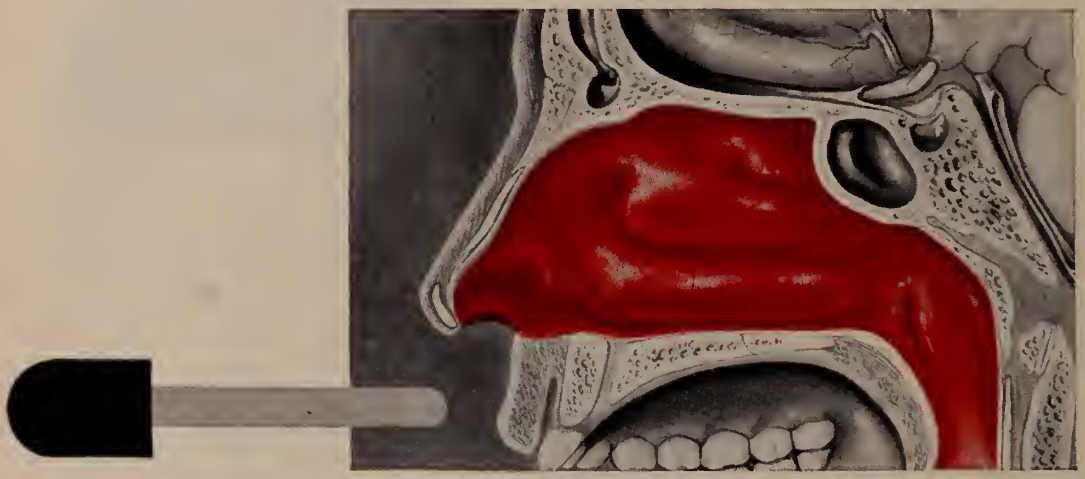
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1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

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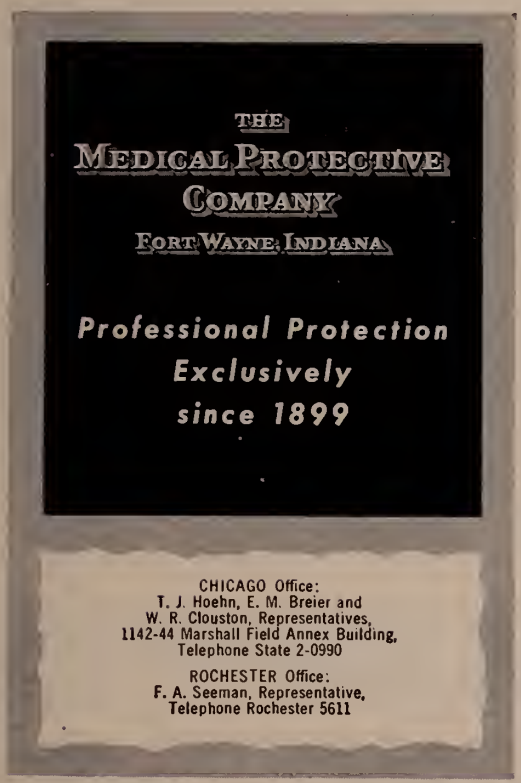
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1. Anspaugh, R. D.: Effects of Dexedrine Sulfate on Nausea and Vomiting of Pregnancy, Am. J. Obst. & Gynec. 60:888 (Oct.) 1950.

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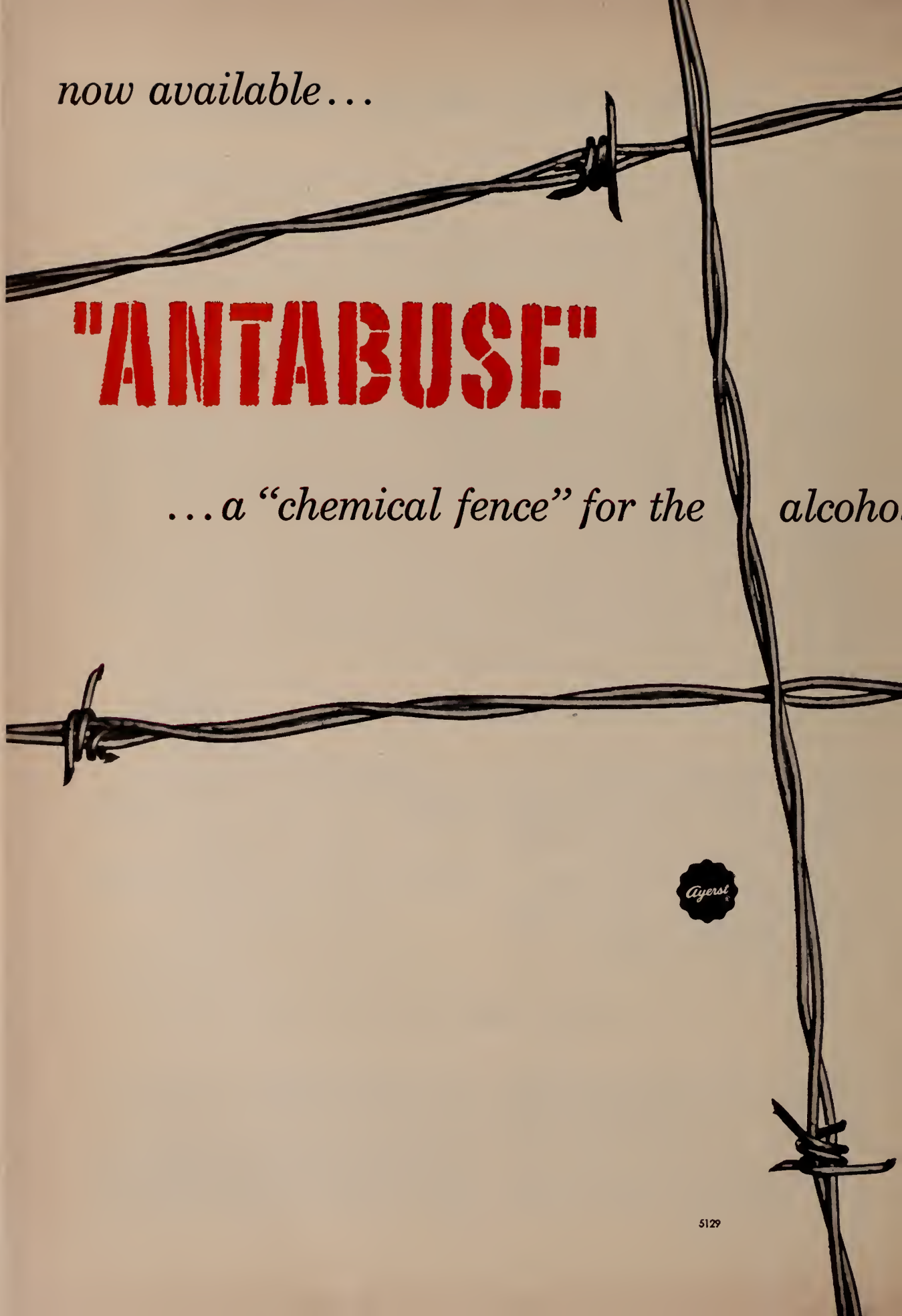
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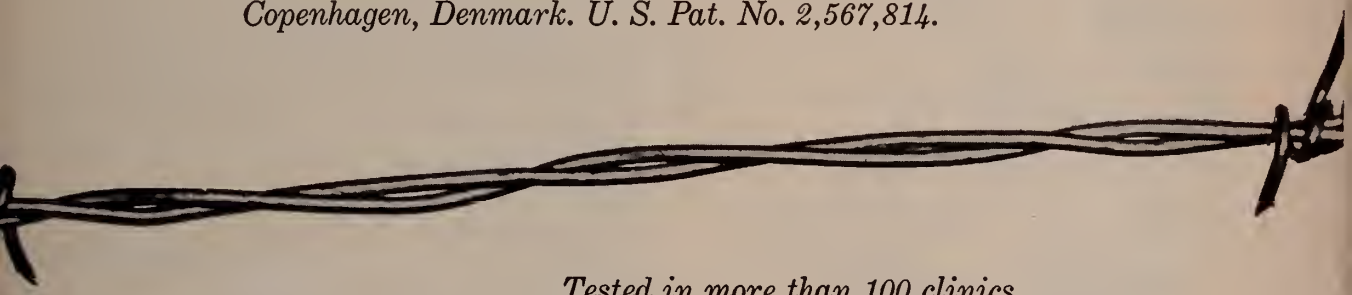
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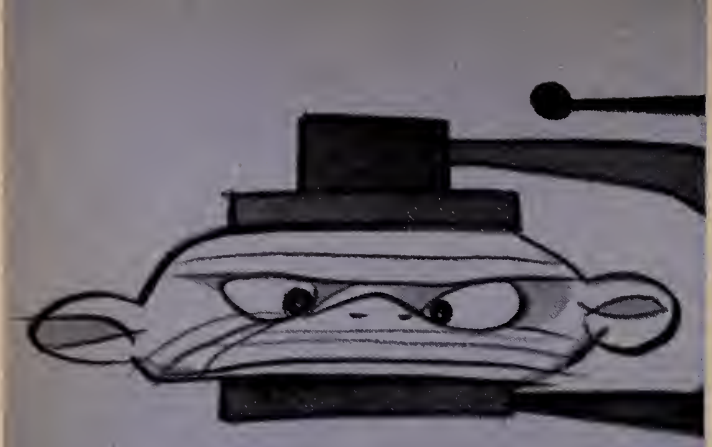
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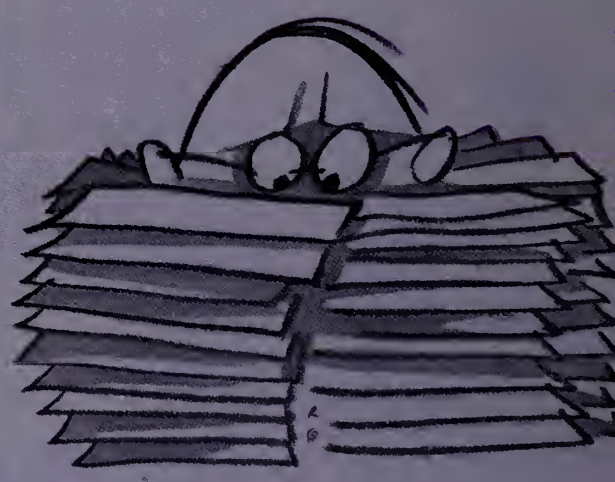


pressure

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work



worry



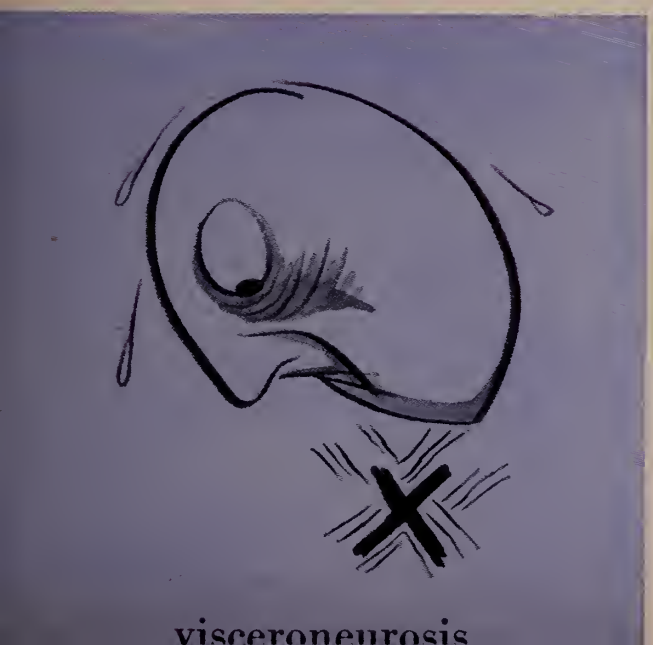
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1. Hock, C. W.: J. Med. Assn. Ga. 40:22, 1951 • 2. Hufford, A. R.: J. Mich. St. Med. Soc. 49:1308, 1950 • 3. Chamberlin, D. T.: Gastroenterology 17:224, 1951 • 4. Pakula, S. F.: To be published •

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Freis, E.D.: Veratrum Viride and Hypertension, Correspondence, J.A.M.A. *144*: 1023 (Nov.18) 1950.

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Gropper, A.L.; Surtshin, A., and Hedrick, J.T.: Effects of Veriloid on Essential Hypertension, A.M.A. Arch. Int. Med. *87*:789 (June) 1951.

Yonkman, F.F. Neurogenic Hypertension, Chemical Approaches to Its Amelioration, J. Michigan M. Soc. *50*:160 (Fed.) 1951.

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POSITIVE, PROLONGED RELIEF In tests conducted by otorhinolaryngologists and allergists on patients with common colds, sinusitis, allergic rhinitis including hay fever and vasomotor rhinitis, excellent results were achieved in nearly all cases. There was prompt, prolonged decongestion without compensatory vasodilatation. Repeated doses did not reduce the consistent effectiveness.

SUPPLIED:

Neo-Synephrine Thenfadil Solution, bottles of 30 cc. (1 fl. oz.) with dropper.

Neo-Synephrine Thenfadil Jelly, ⅜ oz. tubes with nasal tip.

WELL TOLERATED — NO DROWSINESS

Dose: 2 or 3 drops up to ½ dropperful three or four times daily.

Neo-Synephrine Thenfadil solution contains 0.25 per cent Neo-Synephrine hydrochloride and 0.1 per cent Thenfadil [N,N-dimethyl-N′-(3-thenyl)-N′-(2-pyridyl) ethylenediamine] hydrochloride in an isotonic buffered aqueous vehicle.

Also Jelly: Neo-Synephrine 0.5 per cent and Thenfadil 0.1 per cent.

Winthrop-Stearns INC.

NEW YORK 18, N. Y. • WINDSOR, ONT.

1. Hansel, F. K.: Allergy of the Nose and Paranasal Sinuses. St. Louis, C. V. Mosby Co., 1936, p. 769.
2. Lands, A. M., Hoppe, J. O., Siegmund, O. H., and Luduena, F. P.: *Jour. Pharmacol. & Exper. Therap.*, 95:45, Jan., 1949.
3. Luduena, F. P., and Ananenko, E.: *Jour. Allergy*, 20:434, Nov. 1949.

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more effective against



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"More effective in ringworm of the scalp than any other topical agent."[1]

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In "athlete's foot" a combined cured and improved rate of 95% has been obtained.[1]



Also indicated in

tinea corporis
tinea cruris
tinea versicolor
tinea of the nails

"broad antifungal spectrum ...good cutaneous tolerance."[1]

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5% tincture . . . ointment . . . powder . . .
sprayed, applied with cotton or dusted on

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1. Stritzler, C.; Fishman, I. M., and Laurens, S.: *Transactions New York Acad. Sc., 13*:31, Nov., 1950.

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ASTEROL DIHYDROCHLORIDE 'ROCHE'—BRAND OF DIAMTHAZOLE DIHYDROCHLORIDE [2-DIMETHYLAMINO-6-(β-DIETHYLAMINO ETHOXY)-BENZOTHIAZOLE DIHYDROCHLORIDE]



NEW APPROACH TO TREATMENT OF COUGHS!

Antosen

Squibb Liquid Cough Sedative

new simplified formula of two essential ingredients

combined sedative—anti-secretory effect

contains no expectorants

soothing without excessive drowsiness

pleasant-tasting, fruit-flavored

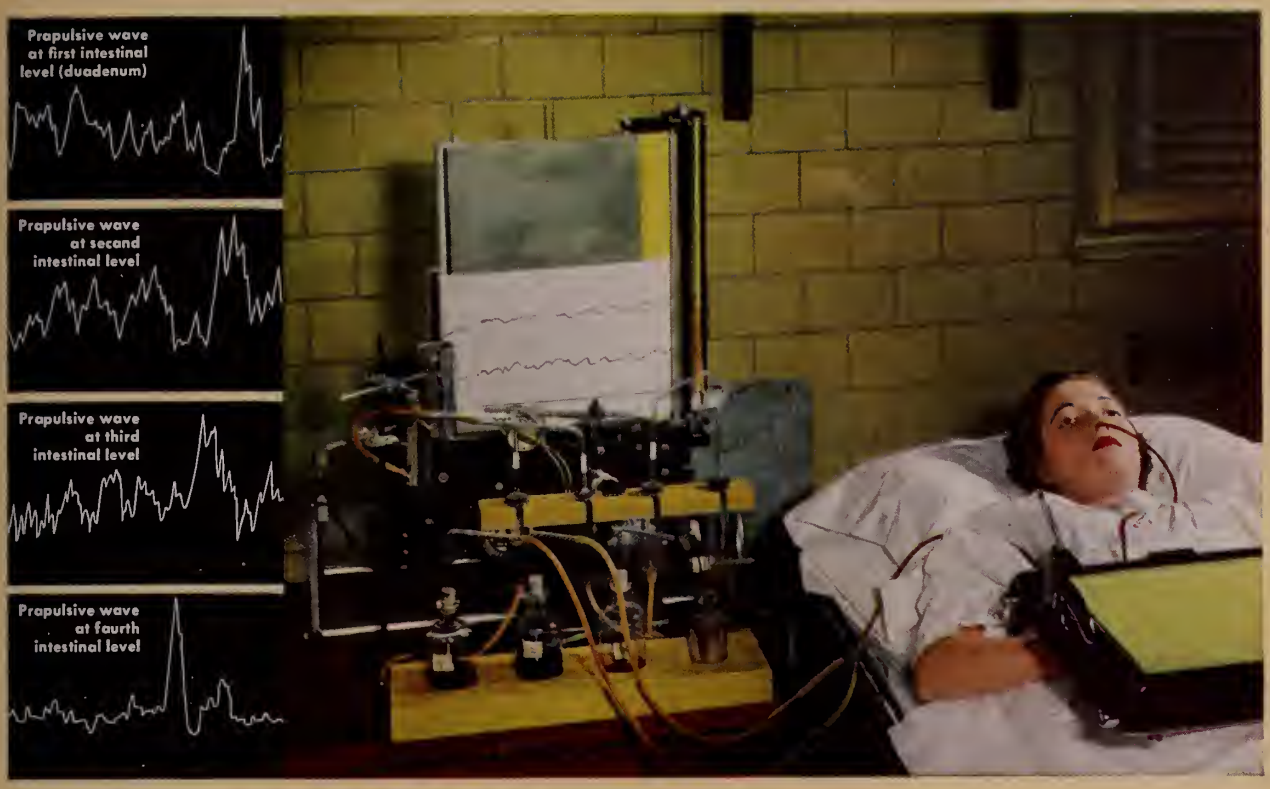
Antosen is for coughs due to common colds or associated respiratory infections. Useful also as a sedative base to which expectorants and/or other drugs may be added. Supplied in pints and gallons.

contains per fluid ounce:

Prophenpyridamine maleate	25 mg.
Codeine phosphate	65 mg.
Alcohol	5%

'ANTOSEN' IS A TRADEMARK OF E. R. SQUIBB & SONS

SQUIBB

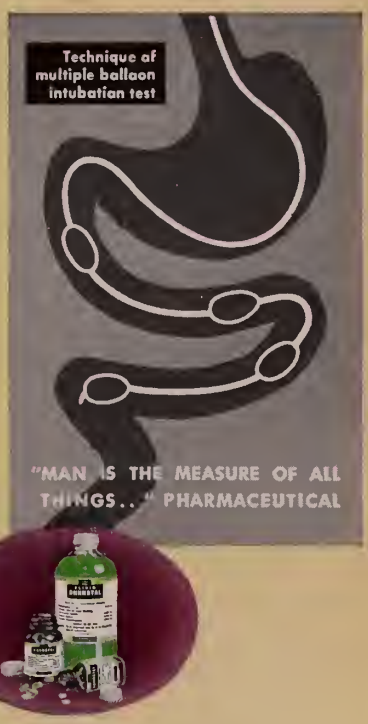


Spasmolysis at its Best . . . by

LIVING TEST

Intubation studies[1,2,3] increasingly confirm the findings of controlled clinical tests and broad professional experience; they dramatically demonstrate the *marked superiority of natural belladonna alkaloids* over the synthetics in relieving smooth muscle spasm.[2,3]

Donnatal employs precise proportions of the principal alkaloids of belladonna, together with a minimal phenobarbital dosage, to intensify the belladonna effects and help correct emotional factors contributing to the provocation of spasm.



REFERENCES: 1. Chapman, W. P., Rowlands, E. N., and Jones, C. M.: New England J. Med., 243:1, 1950. 2. Kramer, P. and Ingelfinger, F. J.: Med. Clin. North America, 32:1227, 1948. 3. Posey, E. L., Bargen, J. A., and Dearing, W. H.: Gastroenterol., 11:344, 1948.

FORMULA: Each tablet, each capsule, and each 5 cc. (1 teaspoonful) of Elixir, contains 0.1037 mg. hyoscyamine sulfate, 0.0194 mg. atropine sulfate, 0.0065 mg. hyoscine hydrobromide, and 16.2 mg. (¼ gr.) phenobarbital.

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WHENEVER and WHEREVER spasm of smooth muscle causes pain or dysfunction

First aid for the *"digestive casualty"*

Entozyme greatly simplifies a broad therapeutic approach to many often complex disturbances of the gastro-intestinal tract, through its provision of potent amounts of the principal digestive enzymes: pepsin, pancreatin (with its lipase, amylase, and trypsin), and bile. Its special "tablet-within-a-tablet" construction controls the release of each essential digestive enzyme at its own appropriate gastro-enteric level... in its optimal state of enzymatic activity. This unique action explains the relief gratifyingly elicited in so many cases of pathologic or functional impairment of the digestive process.[1,2,3]

REFERENCES: 1. Kammandel, H. et al.: Bull. N. Y. Med. Coll., Flower & Fifth Ave. Hosps. (in press). 2. McGavack, T. H. and Klotz, S. D.: Bull. N. Y. Med. Coll., Flower & Fifth Ave. Hosps., 9:61, 1946. 3. Weissberg, J. et al.: Am. J. Dig. Dis., 15:332, 1948.

FORMULA: Each tablet contains 300 mg. pancreatin, U.S.P., 250 mg. pepsin N.F., and 150 mg. bile salts.

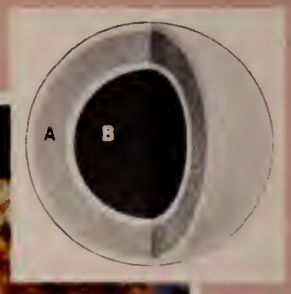
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While *Ray-Formosil* seldom produces the immediate dramatic effects of hormonal preparations, it is consistently effective when used adequately, and it obviates the two serious disadvantages of "wonder drug" therapy, namely, severe toxicity and high cost. As first-choice conservative therapy, *Ray-Formosil* provides the opportunity to effect symptomatic relief without danger of precipitating the undesirable physiologic responses characteristic of hormonal medication.

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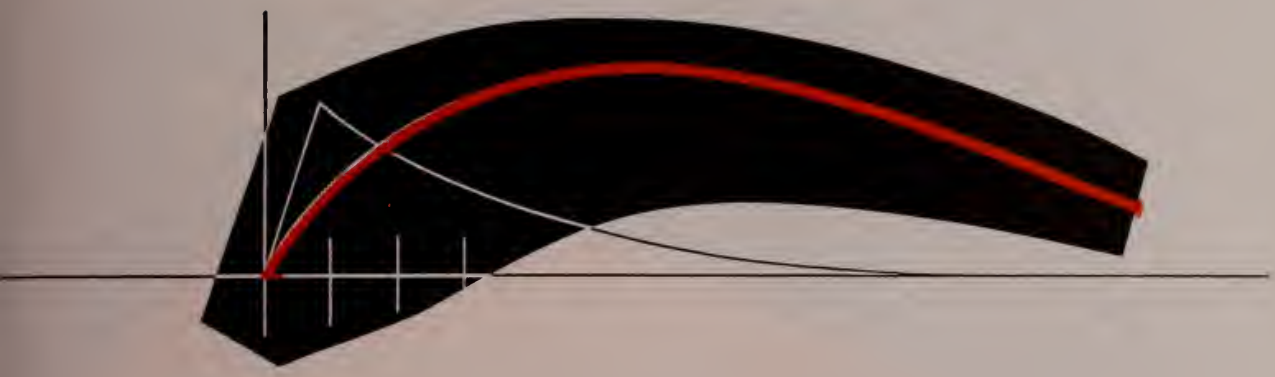
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SUPPLIED: ACTHAR Gel is supplied in multiple dose vials of 5 cc. in two concentrations:
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ACTHAR *Gel*, the new LONG-ACTING repository preparation for deep subcutaneous and intramuscular injection, greatly facilitates ACTH therapy for both the patient and the physician. A single daily injection is sufficient in the many cases requiring less than 80 I.U. (mg.) per day. Remission of symptoms may often be maintained by two to three injections per week. Office treatment for the ambulatory patient and home treatment for the bedridden become readily applicable, with considerable economy to the patient. ACTHAR *Gel* is well-tolerated locally and possesses the full efficacy of aqueous ACTHAR.

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Literature and directions for administration of ACTHAR *Gel*, including contraindications, available on request.

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small, easily swallowed, not enteric coated—a convenient form for older children and adults.

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pleasantly flavored and particularly adapted to treatment of children, but may be given whenever liquid medication is preferred.

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8. Kelly, H. T.: Penn. M. J. 51:999, 1948.

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an easy-to-take caloric supplement of small volume whose 1 micron-sized fat particles are better tolerated than the large dietary fat globules.

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good for the appetite. It is not a satiety-producing medication; rather it may cause "a very marked increase in appetite" described as "a constant urge to eat" in a significant number of patients.[1]

Liquimat Oral, providing 120 calories per fluidounce, contains vegetable oil 40% w/v and dextrose, anhydrous, 10% w/v, preserved with sodium benzoate 0.1%.

Supplied in one pint bottles

1. [illegible] T. B. Gray, R. E. [illegible] and [illegible] P. J. J. [illegible] Dis. A. 2: 187 (March) 1951.

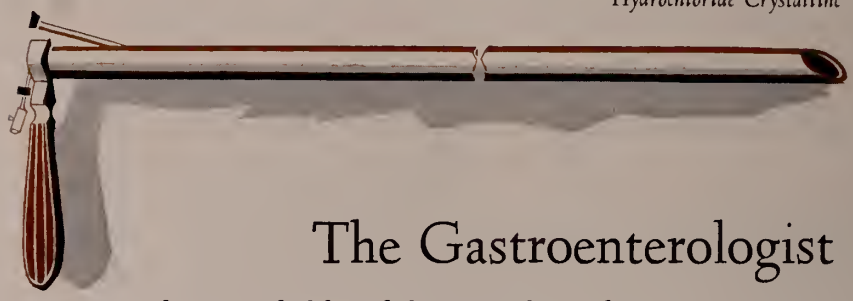
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recognizes the remarkable inhibiting effect of aureomycin on a great number of organisms, especially those commonly found in the gastrointestinal tract. It is of great value in the preparation of patients for surgery of the bowel or biliary tract, as well as in the medical management of infections in these areas. Aureomycin is also highly effective in intestinal amebiasis. Aureomycin is peculiarly adapted to the treatment of many biliary and hepatic infections, because of the high concentrations it attains in the bile and because of its protection of the hepatic parenchyma from bacterial necrosis. Aureomycin is indispensable in gastroenterology.

Packages

Capsules: Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. distilled water.

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Extensive evidence based on three years' clinical experience has shown that CORTONE controls both objective and subjective manifestations of rheumatoid arthritis in virtually all cases; in many of these patients, CORTONE has been used for prolonged periods of time.

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Cortone Acetate Ophthalmic Ointment 1.5%, 3.5 Gm. ophthalmic tubes.

Literature on Request

**CORTONE* is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.*

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Sedative-antitussive effects of Methajade control sleep-robbing paroxysmal cough—allow patients to get needed rest.

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METHAJADE® spares your patients the needless violence of exhausting, "unproductive" cough—without depriving them of the benefits of normal expectoration.

Because it contains *methadone*, the synthetic analgesic-antitussive, METHAJADE is capable of suppressing the irritability of the cough reflex without blocking it entirely.

Because it contains potassium citrate and diluted phosphoric acid, METHAJADE promotes the liquefaction and loosening of mucus, facilitating the expulsion of bronchial exudate and debris.

Because it relaxes smooth muscle, including that in the tracheobronchial tree, METHAJADE is effective in relieving the bronchial spasm often associated with coughs.

Together, these actions tend to *decrease* the frequency and *increase* the efficiency of coughing, and to relieve bronchial spasm. METHAJADE is therefore well qualified as a practical aid in achieving the modern objectives of cough control:

(1) *to* preserve *the natural physiologic benefits of the cough*—

(2) *to* reserve *the act of coughing for "productive" expectoration.*

Composition—METHAJADE is a sugar-free antitussive with a delicious, fresh, lime flavor. Each 30 cc. (1 fl. oz.) contains:

Methadone hydrochloride* (*d,l*-6-dimethylamino-4,4-diphenyl-3-heptanone hydrochloride)	10 mg.
WARNING: may be habit forming.	
Propadrine®, phenylpropanolamine hydrochloride	0.12 Gm.
Potassium citrate	1.2 Gm.
Diluted phosphoric acid	4.5 cc.
Alcohol 5%	

Average Dose for Adults: 1 to 2 teaspoonfuls every three or four hours.

CHILDREN:

(*note:* METHAJADE *should not be administered to children under 2 years of age. In children 2 years of age or older,* METHAJADE *should be used only in cases of severe, intractable cough.*)

Two years: ¼ teaspoonful not more often than every four hours.

Five years: ½ teaspoonful not more often than every four hours.

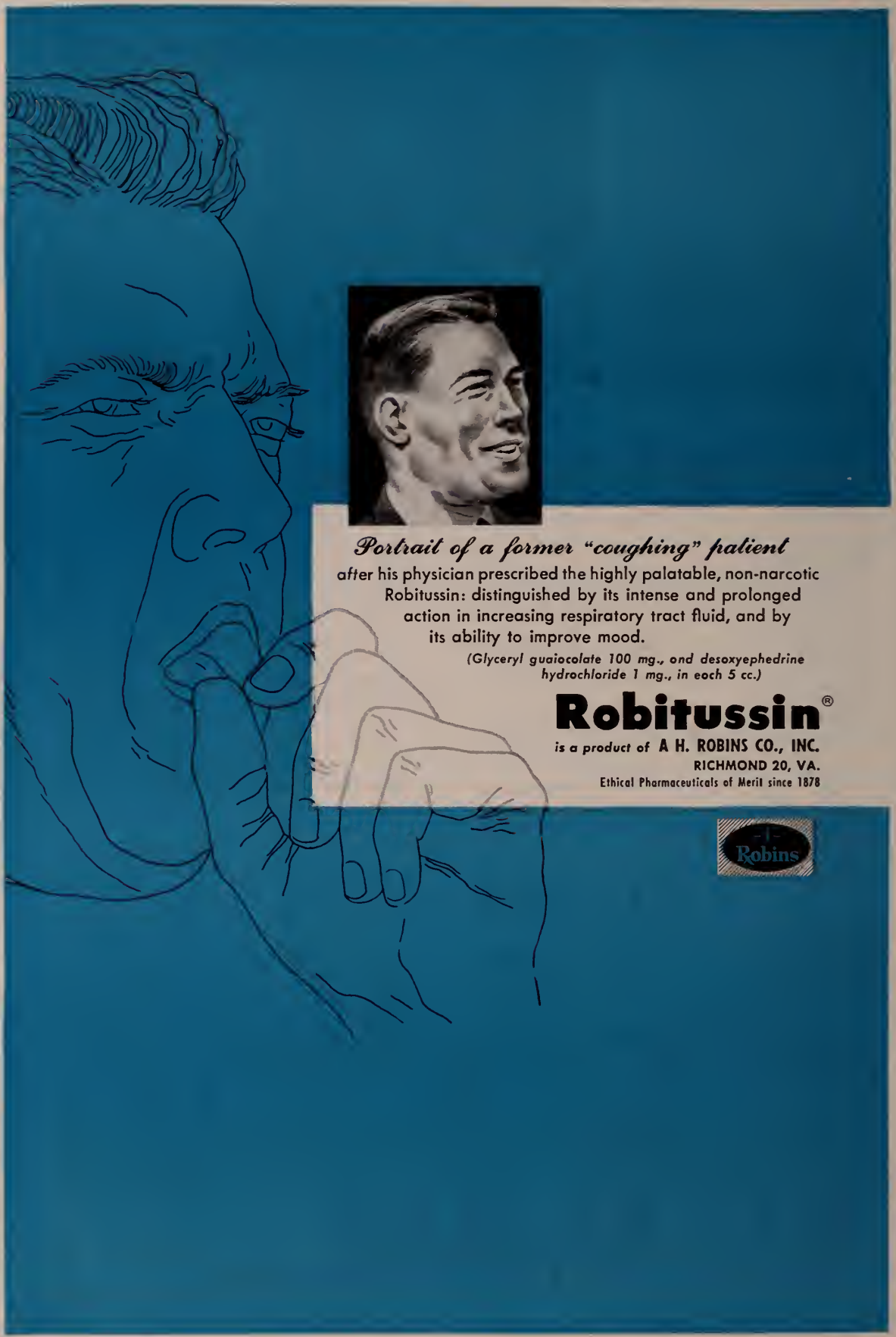
Ten years: 1 teaspoonful not more often than every four hours.

Packaging—METHAJADE is supplied in pint Spasaver® bottles and gallon bottles.

Sharp & Dohme, Philadelphia 1, Pa.

**The analgesic potency of methadone hydrochloride is—weight for weight—approximately equivalent to that of morphine. It controls cough as well as, or better than, codeine. Methadone hydrochloride is subject to the provisions of the Harrison Narcotic Act.*

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Portrait of a former "coughing" patient

after his physician prescribed the highly palatable, non-narcotic Robitussin: distinguished by its intense and prolonged action in increasing respiratory tract fluid, and by its ability to improve mood.

(Glyceryl guaiocolate 100 mg., and desoxyephedrine hydrochloride 1 mg., in each 5 cc.)

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A NEW HYPOALLERGENIC PENICILLIN SALT

Through the routine use of Compenamine, reactions to penicillin can be reduced significantly below that encountered with other available forms of penicillin G. This hypoallergenic characteristic of Compenamine permits its use even in known penicillin reactors; in this group it reduces the incidence of reactions by at least 80 per cent. Thus Compenamine brings new safety to penicillin therapy.

A research development of C.S.C. Pharmaceuticals, Compenamine is generically designated as *l*-ephenamine penicillin G. Its clinical behavior and therapeutic performance are identical, unit for unit, with comparable dosage forms of procaine penicillin. Nearly insoluble in water and oil, its dosage forms are of the repository type.

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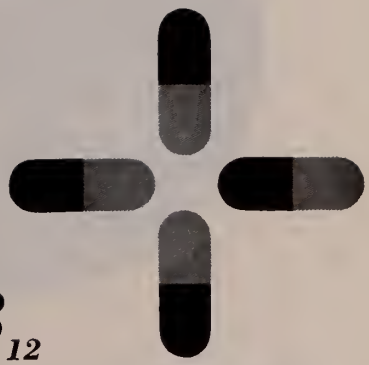
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BENYLIN EXPECTORANT
contains in each fluid ounce:

BENADRYL® HYDROCHLORIDE	80 mg.
AMMONIUM CHLORIDE	12 gr.
SODIUM CITRATE	5 gr.
CHLOROFORM	2 gr.
MENTHOL	1/10 gr.

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BENYLIN EXPECTORANT rapidly relieves cough because it combines BENADRYL hydrochloride (10 mg. per teaspoonful), with established non-narcotic remedial agents. BENYLIN EXPECTORANT liquefies mucous secretion, relaxes the bronchial musculature, soothes irritated mucosa and relieves nasal stuffiness, sneezing and lacrimation. Its mildly tart taste appeals to adults as well as children.

Benylin® EXPECTORANT



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DECONGESTANT
ANTISPASMODIC
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DEMULCENT
NON-NARCOTIC
PALATABLE

DOSAGE: One or two teaspoonfuls every two to three hours. Children, one-half to one teaspoonful every three hours.
Supplied in 16-ounce and 1-gallon bottles.

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The VITERRA formula includes a balanced assortment of the essential minerals and vitamins required for the maintenance of health.

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2. Everett: Med. Biochem., Sec. Ed., Inorganic Substances, Gen. Factors in Mineral Metabolism, p. 568.

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Mixed Tocopherols (Type IV)	5 mg.
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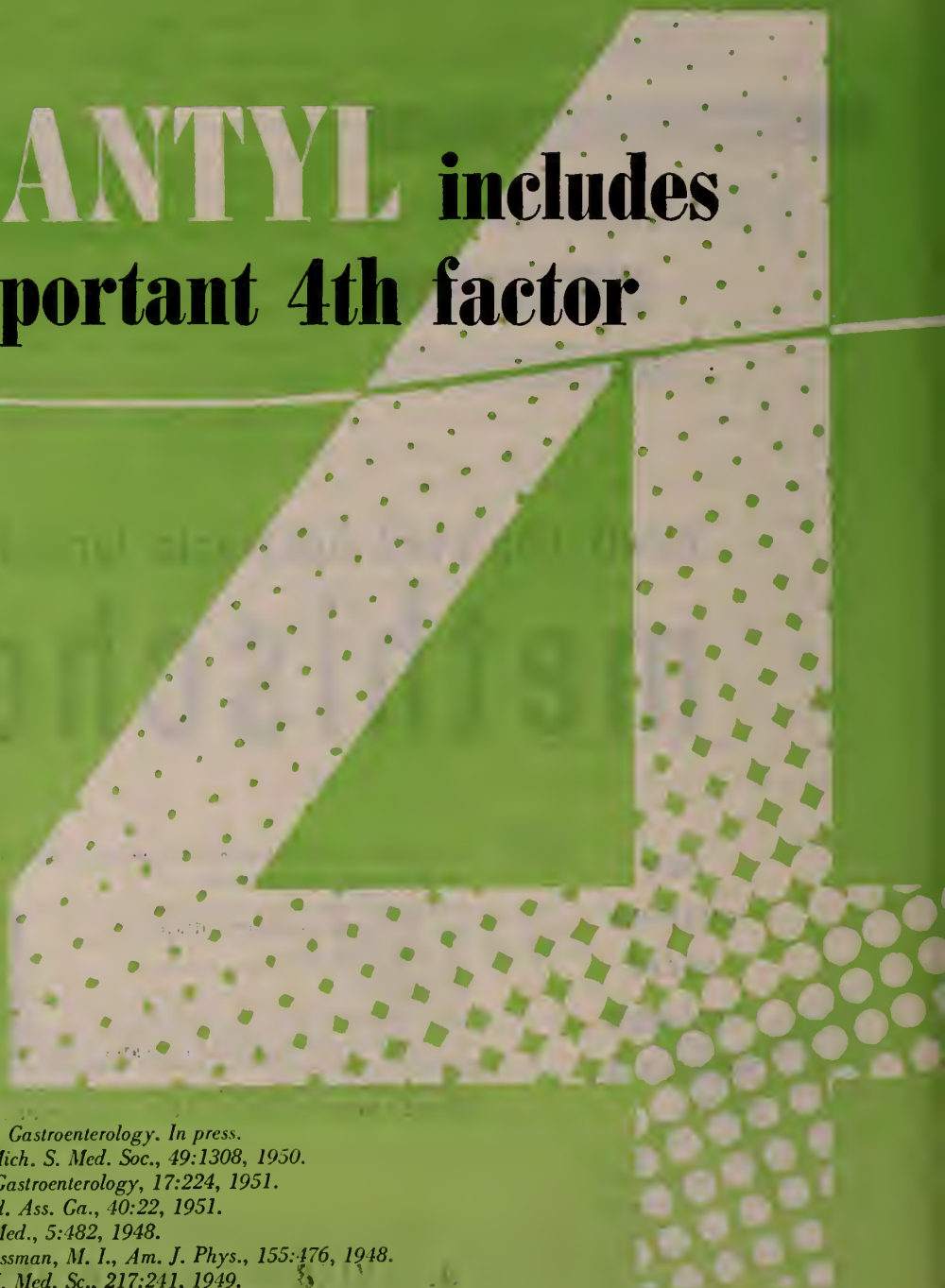
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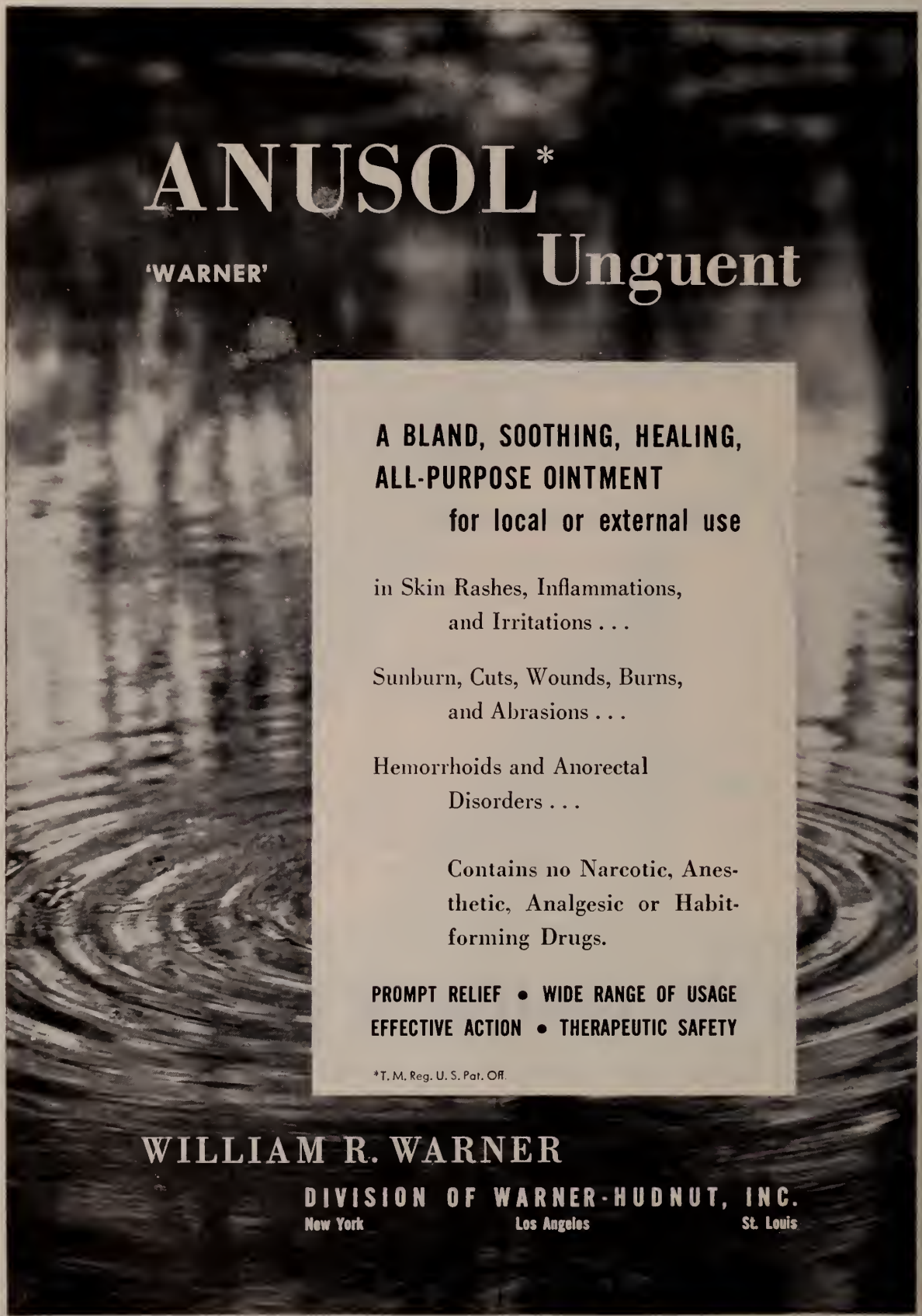
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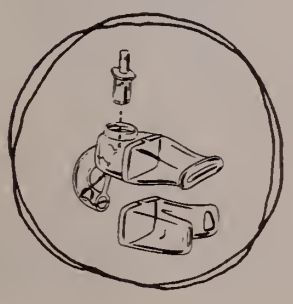
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*Reg. Trade Mark for Abbott Sifter Cartridge. AEROHALOR and AEROHALOR Cartridge patented in U. S. and Foreign Countries.



1. Krasno, L., and Rhoads, P. (1949), The Inhalation of Penicillin Dust, Amer. Prac., 11:649, July.

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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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Vol. 100, No. 5 November, 1951

DR. JOSEPH B. SCHREITER — OUTSTANDING GENERAL PRACTITIONER

Dr. Joseph B. Schreiter of Savanna, Illinois, has been selected as the outstanding general practitioner of Illinois for 1952.

For several months all county medical societies in Illinois have been urged to submit their candidate for this honor, and many applications had been received when the selection was made October 14. The secret committee of the Illinois State Medical Society, representing all parts of the state, looked over the material on each candidate, then, by a process of elimination and a vote, selected Dr. Schreiter.

Dr. Schreiter was born in Darlington, Wisconsin, January 4, 1875, one of four children of David and Hannah Bleasdale Schreiter. After being graduated from Darlington High School in 1889, he took a pre-medical course at the University of Wisconsin. Later he entered Rush Medical College in Chicago, from which he was graduated in 1896. Following special work at the Presbyterian and Cook County Hospitals, he started his practice in Savanna, and has remained there in continuous practice for fifty-five years. He was elected coroner of Carroll County in 1900, and held that office continuously for forty-eight years, which is believed to be a record.

Dr. Schreiter married Miss Besse Beaver at Mt. Carroll, Illinois, September 30, 1903. They have one child, Jesse, a mathematician doing special work for the Army at Ohio State University, Columbus. Dr. Schreiter has maintained his present office in the National Bank of Savanna Building since 1912.

Early in World War I, Dr. Schreiter was commissioned as a First Lieuenant in the Medical Corps, and was a major before being separated from service. He was in France for twenty-two months. He remained in the Reserve, however, and before retirement became a Colonel. He was an organizer, and the first commander of the American Legion Post at Savanna in 1919.

Dr. Schreiter has always been intensely interested in all civic projects and has held many positions locally. He was a member of the school board for a number of years, and also served for some time as city health officer. He has been local surgeon for the Burlington and for the Chicago, Milwaukee and St. Paul Railroads for a considerable period of time. Dr. Schreiter is chief of staff of the Savanna City Hospital. He has been very active as an officer and member of the Board of Directors of the Savanna Savings Building and Loan Association and also of the National Bank of Savanna. Always interested in medical progress, especially obstetrical work, he has been present at the birth

of more than 4,000 babies, and still maintains this interest.

Wednesday, August 8, 1951, the city of Savanna celebrated "Doc Schreiter Day," starting with a parade in the late forenoon, then to the Old Mill Park, where lunch was served, followed by a program, and with Dr. Andy Hall of Mt. Vernon as the principle speaker. On an unusually hot day, more than 4,000 friends of Dr. Schreiter turned out to pay their respects to one they all admired for his fine work, friendly interest in their welfare, and as an outstanding citizen. Business houses were all closed for the afternoon, and most of the 5,000 citizens of Savanna joined in the festivities.

Dr. and Mrs. Schreiter both enjoy excellent health and have mutually been interested in the many problems of medicine, the community, and the nation, and have given unstintingly of their time throughout their married life.

Dr. Schreiter will be the candidate from the Illinois State Medical Society for the outstanding general practitioner of the nation. The selection will be made by the American Medical Association House of Delegates at the Clinical Session to be held in Los Angeles, December 4, 1951. The thousands of friends of Dr. Schreiter, both in and out of the medical profession, are unanimous in the opinion that he is well qualified for this honor.



Joseph B. Schreiter, M.D.

DISCRIMINATE USE OF ANTIBIOTICS

From time to time it becomes necessary to wave the red flag in front of our popular antibiotics to discourage their indiscriminate use by certain laymen and physicians. Complications and side-effects occur and to avoid repercussion we must yield to common sense and good judgment. The toxic effects of penicillin, streptomycin, bacitracin, aureomycin, chloramphenicol and terramycin are well known. The possibility of sensitizing patients to these agents also has been mentioned on many occasions. These drawbacks are reasons enough to recommend their use only when necessary.

During the past few years, the warnings relative to the possibility of developing a strain of bacteria resistant to the antibiotics is becoming less theoretical and more real. The use of these drugs has eliminated from a large percentage of our population the organisms which are sensitive to the antibiotics. But the flora is being replaced by organisms which are resistant to penicillin and related drugs. There is evidence that serious and even fatal infections from penicillin resistant staphylococci are occurring. An enzyme which Abraham and Chain have designated as penicillinase also has been isolated from extracts of these organisms indicating that a potent penicillin inactivator is being produced. It has been obtained from a number of cases where penicillin has failed in the treatment of staphylococcal infections.

It is believed that the germs develop resistance when the concentration of the antibiotic is maintained at below effective bactericidal levels. The non-resistant strains die off and leave a resistant strain which may be suppressed at first but ultimately regrows and leaves in its wake a strain capable of withstanding the effect of the antibiotic.

The Council on Pharmacy and Chemistry has published also a warning statement dealing with the use of aureomycin, chloramphenicol and ter-

ramycin. These antibiotics are capable of transforming the flora of the mouth and intestine by suppressing the normal susceptible bacteria and replacing them with an abnormal bacteria of flora. They mention specifically the possibility of leaving monilia and other yeast-like organisms. This is not serious so long as the monilia remain in the intestinal tract but if the transformation occurs in a lung abscess or bronchiectatic cavity, the outcome may be unfavorable to the patient.

According to the Council, "Deaths from pulmonary moniliasis following therapy with the new antibiotics are known. Also instances of cutaneous moniliasis mistaken for sensitivity have been noted when the newer antibiotics were used in the treatment of disease."

We admit that while moniliasis is rare there is always a possibility that it might develop. We can avoid trouble by acquainting ourselves with the proper indications for antibiotic therapy and by not using them indiscriminately. Use dosages of single agents which have proved to be adequate and effective.

Council on Pharmacy and Chemistry: *Warning Statement to be Included in Aureomycin Hydrochloride, Chloramphenicol and Terramycin Hpdrochloride Labeling, J.A.M.A.,* 145:1267 (*April* 21) 1951.

THE RISE OF MEDICAL SPECIALISM IN ILLINOIS

By David J. Davis, M.D.*
Chicago

The most characteristic feature of medicine in Illinois during the period 1850 to 1900 was the gradual rise and evolution of the modern specialties. The main reason for this emergence was the progress that was occurring at that time in the basic sciences throughout the western world. Technological methods, discovered and used in clinics and laboratories, were brought to bear upon the solution of the problems of disease in a multiplicity of ways. These advances as they were applied during this half century were to change fundamentally the practice of medicine in its every aspect.

It is largely on this account that the plan of approach in this second volume of the Medical History of Illinois is altogether different from that in Volume I. In Volume I, the history related chiefly what the doctor did in his daily work among the people, as they came to him or he went to them. As their various ailments were presented to him he did the best he could with little or no regard to specialization. With differential diagnosis in its infancy it was inevitable that many different diseases, with a few symptoms in common, fevers for example, were grouped together, and all were given the same treatment regardless of their true nature.

Furthermore, Volume I of this History is based largely on an orderly regional and/or county plan, telling in a general way and by personal accounts what had transpired in medicine both by the physicians and by the people in the various localities. The entire state in this way was fairly adequately covered. Little variation existed in the experiences either of the doctors or of the people, except perhaps those experiences which resulted from differences in disease distribution in various parts of the state. Such differences on the whole were not very great. Fevers, especially malaria, were common, as were tuberculosis, contagious diseases, diarrheas, dysentery, cancer, pneumonias, bronchial troubles, wounds, infections, abscesses, injuries of many kinds especially fractures, childbirths, and their complications and diseases of the eye, the ear, the throat and the skin. Poisonings by snake bite, poison ivy, white snake root (milk sickness) and some others were less common. Any or all of the above afflictions could appear in a busy doctor's office almost any day, requiring and usually receiving prompt personal attention from the doctor himself. At that time such doctors included the greatly revered family physicians who, as general practitioners, rendered an indispensable service to the people, a service which during those years could not be obtained in any other way. In the rural areas, as well as in the smaller communities, this type of general service has persisted to this day, and, though receding, no doubt will continue for many years to come.

But at approximately the midcentury mark (1850), this general plan of procedure both for the doctor and for the patients slowly but surely commenced to change. This change began primarily in the large cities and in the medical schools. The inexorable law of specialization began to manifest itself in almost everything

*Permanent Historian — Illinois State Medical Society.

that was being done by the physicians as well as by the people in the home, on the farm, in industry, etc. This trend toward specialization was very gradual. Though it increased at an accelerating rate, even after 50 years, there still existed many competent doctors who managed and treated their patients in principle as they had done in pioneer days.

As already intimated, it was this specialization in medicine which began about 1850 that has made it seem advisable to alter the plan carried out in the first volume, to one that is based on the rise and development of the several specialties. This latter plan seemed to demand that the presentation of the several specialties be allotted to experts qualified in their respective fields. This has been done. These experts for the most part are or have been experienced teachers as well as practitioners. They thus have become familiar with the historical approach to their subjects and have acquired a thorough knowledge of medicine based upon long training and practice.

The first specialists in medicine in the Illinois country appeared among the Indians, primitive and crude as they were. Medical specialization first grew out of the principle of the Division of Labor — a general practice carried on by all races of human beings who enter into the usual relations incident to the art of living. Since man is by nature a gregarious animal, this way of life is one of his basic characteristics.

When the white man first came to Illinois, the American Indians, already there in large numbers, were still living in the stone age. Division of Labor even then was clearly evident in their everyday life. The men did the hunting, fishing and fighting. The women made clothes and tepees, cooked the food, cut the wood, raised the crops and carried on all the menial labor about the camps. Naturally in such a system certain individuals become more expert than others in performing these various activities.

Most matters having to do with health and disease even in the earliest tribes known were in the hands of special groups called medicine men. Living largely in a demon or spirit world, the Indians believed that diseases resulted from the operation of spirits either within or without themselves. The medicine men and the men (or priests) having to do with their religious beliefs were not clearly differentiated. Often they were identical individuals. For the most part these groups were fakirs, witches, charlatans and magicians who practiced the "tricks of their trade" on the sick by presuming to cast out the evil spirits.

In addition to these "spirit men," there were other specialists in this field. A large number were the so-called "herbalists" who devoted their time to wandering through the forests and fields collecting herbs which in the form of decoctions or extracts were used or tested upon themselves or on the sick.

Many of them acquired an uncanny knowledge of herbs of all kinds. These herbs became their "materia medica". The men and women who found and prepared these products sometimes became a group apart. They were looked up to at times with an august respect, or again with fear.

Another group that often became differentiated more or less clearly from the rank and file were the midwives and those having to do with the special diseases of women. In some Indian tribes this specialty was conducted in a private way, and often in separate huts. Even, at times, the patient was left entirely alone as she managed her own labor as best she could and administered whatever therapy the crude Indian practices required.

Still another specialty was physiotherapy and, in particular, that part of this therapy that had to do with hot and cold baths and with the salt waters and springs that were widely distributed in this territory. In the United States are some 2000 mineral springs many of which have hot or warm chemical waters. The Illini country was well supplied with all these waters. At such places, the natives congregated for sweat baths, massage, purging and other treatments. Here, too, animals came in large numbers attracted by the salt thus becoming an easy prey for the Indians. Such localities became the sites of some of our early settlements and cities.

Among the Indians, surgery in an indefinite way was early differentiated from their more general medical practices. Thus arose groups of specialized practitioners of which the bone setters, bleeders, and those who trephined skulls are examples (Paleopathologie. Moodie, Urbana, Ill., 1923. U. of Illinois Press). During times

of war which for many tribes was an almost continuous engagement the care of wounds and of special injuries became the special assignment of these primitive surgeons.

Crude as their medical methods seem to us today, they were no more so than were their efforts in other lines of activity. The Indians took their medical work seriously, with the result that this particular art played a significant role in their lives in many ways. In general, it existed as a universal institution among all the Indian tribes in this country.

The above statements regarding Indian medical specialization are here set forth with the idea in mind that they may furnish a basic, even though a crude and inadequate introduction to the rise of our modern specialties. The underlying principles of evolution and progress are identical in both.

To understand the early development of modern specialism in a limited region such as Illinois, it is necessary to refer to earlier times and to earlier countries for an historical approach to the subject. Such an approach will furnish dependable guiding principles for us to follow.

The beginnings of specialism in medicine among civilized peoples arose far back in ancient times. Those who first limited their work to special organs, like the eye (Code of Hammurabi) or the ear, seem to have been, in principle at least, the initiators. The recognition of surgical practice as a field to some degree different from general medicine, is also ancient. Both were to a variable extent differentiated long before the days of Greece or even of Egypt. Ethnology bears this out. The discovery of surgical instruments in the modern excavations of ancient civilizations also indicates that surgery is very old, perhaps the oldest of all medical procedures. This is on the assumption that childbirth was considered until relatively recent times a physiological process, comparable in some respects to other normal evacuation processes of the body. It was therefore natural that medicine and surgery (even the Barber Surgery) together with some of the organ specialties, having originated so long ago, continued down through the centuries, side by side as it were, until the advent of the scientific specialism of today.

The progress of medicine has been achieved by discoveries made at intervals, here and there, in the various countries of the world. Depending on the nature of these discoveries, a period of time ensues before the concrete discovery becomes available for practical purposes. This "lag"* period depends upon various factors, the two chief ones being (1) transmission of information (usually by printing) and (2) training of competent persons to carry on the technological procedures. The length of this period of time varies from a relatively short one to many years. It is during these years that technics are perfected and as a rule new and valuable observations are made leading to further advancement. As Bacon has written "This Art of Discovery hath, two parts, for either the Indication is made from Experiments to Experiments; or from Experiments to Axioms, which may likewise design new Experiments." (Advancement of Learning).

In a relatively primitive country such as was Illinois during these years (1850-1900), one could hardly anticipate great discoveries of a fundamental nature. And, as a matter of fact, no major discoveries have been recorded in Illinois during this period. Our interest therefore will lie in noting the early application of principles together with the technical improvements that naturally occur during these subsequent periods of extension and dispension.

To illustrate, in Volume I, page 223, Zeuch tells of the first anaesthetic given to a patient in Illinois. In 1846 in the amphitheater of Rush Medical College, Chicago, Dr. Charles H. Quinlan gave ether in a case of an amputation of a finger. This date was only four years after Dr. Long first used ether in Georgia for the removal of a tumor two years after Dr. Jackson and Dr. Morton used it in filling a tooth (1844) and one year *before* Dr. Simpson (1847) used chloroform in childbirth cases in Edinburgh, Scotland.

One will admit that for that day the transmission of information as indicated above was surely a remarkable accomplishment. Dr. Quinlan (and there were many like him) must have been on the alert for the latest and best in medicine. The discovery of practical anaethesia and its relatively rapid application were most timely in view of its usefulness during the Civil War, which was to follow so shortly thereafter; as

*"Lag" has been defined as that unpredictable period between the discovery and the pay-off.

well as for the discoveries in antiseptic surgery during the half century under consideration.

Again, just at the close of the last century in 1895, Roentgen discovered the x-ray. In a surprisingly brief time the news of this discovery encircled the world. In Illinois, within the year (1895) Dr. Michael Hewitt of Galesburg was able to obtain an excellent skiagraph of Dr. Thomas Shastid's hand. Dr. Shastid thinks it was the first x-ray picture taken in the Western Hemisphere (My Second Life. Thomas H. Shastid. 1944, p. 32. George Wahr, publisher. Ann Arbor, Michigan).

For the examination of bones and other dense tissues or parts of the body, progress was rapid. For many other purposes especially therapy and treatment of disease, the advance, though somewhat more retarded, was nevertheless progressive and has continued from time to time to excite the world with new observations and techniques.

Finally one should not fail to mention the fact that the nature and incidence of diseases in a given region are certain to have an influence on the rapidity and the trends of medical specialization. Where fevers occur, there febrifuges will be used and studied. In a pioneer period, wounds, fractures and local infections will require surgery. In Illinois specifically, the trachoma area occurring in the southern part of the state has required the services of eye doctors for many years.

Such experiences surely will encourage a few doctors to become more or less expert in some branch of medicine; in other words they become specialists to a greater or less degree during the natural course of events.

Many more examples of the rapid dissemination of medical information together with its application will appear in the several special sections or chapters in this Volume. Progressive and alert doctors, hospitals, clinics, medical colleges and medical literature all have assisted in the dissemination of this special information which has resulted both in the relief of incalculable suffering, and in the prolongation of innumerable lives.

Thus did medical specialism grow and evolve in Illinois.

SCIENTIFIC EXHIBITS FOR 1952 ANNUAL MEETING

The 1952 Annual Meeting of the Illinois State Medical Society will be held at the Hotel Sherman, Chicago, May 13, 14, 15. As has been the custom in recent years, an outstanding feature of this annual meeting will be the Scientific Exhibit. Applications for space should be made immediately to the Chairman of the Committee on Scientific Exhibits; Coye C. Mason, M.D., 551 Grant Place, Chicago, Illinois.

Complete information relative to the two types of exhibits which will be used in this fine display, and all pertinent data will be given by Dr. Mason. He will likewise send the necessary application form to those desiring to participate in the scientific exhibit.

Although more exhibit space will be available than was used for the 1951 Annual Meeting, it is quite obvious that all of it will be assigned in the near future. It is necessary, therefore, that applications be received and returned to Dr. Mason at the earliest possible moment.

THE FAMILY DOCTOR

Until the last few years the family doctor has been a rapidly fading figure in American Medicine. The public, in the main through overemphasis upon the scientific achievements of our own group, has been weaned away from the concept of the doctor as an understanding family friend.

The 'man in white grappling with death" has become the epitome of the physician in the eyes of many of the public. The first result has been that the family doctor has lost favor in the eyes of his own clientele. A secondary result is that men have turned away from general practice.

Now we find that the most ill-served area is that area in which no family doctor is present.

In the five years immediately past vastly increasing emphasis has been placed on raising the status of the general practitioner and on bringing a family doctor to the small towns which so desperately need one.

It should be a part of every medical society's job to bring forcefully to the attention of the public the advantages of having a family doctor. This is not to imply in any way that the various specialty groups should be criticised or limited.

The family doctor is a man who is well able

to see after the majority of medical needs of any family group. He occupies the enviable position of having a personal knowledge of this family group and every member of it.

In this position he is an excellent judge of the relative weight of the psychic and somatic factors in any complaint. A complete knowledge of the past history of an individual, such as only he can possess, in invaluable in diagnosing and treating most disease.

The conscientious family doctor will request consultation when he feels that the best interest of the patient demands it. And he will "stand in" with the qualified specialist of his selection at any major procedure done upon his patient.

This liaison between family doctor and specialist is of incalculable benefit to the patient. It should be strongly fostered by both medical groups and the public. Far too often the opposite obtains.

The family doctor can afford to render general medical care for less money than can a specialist or a specialized group. This is not to say that he can do the more complicated procedures of diagnosis and treatment any cheaper. But the majority of medical calls are for problems of a simple nature.

One of the current objections to American medicine is its high cost. While medical costs have not risen in accord with other costs, the objection has some basis in fact. The costs of individual procedures or of office calls have not risen greatly but the use of these procedures has increased.

In many instances the family doctor is quite capable of handling all aspects of an illness but, if the same illness were to be investigated in a medical center, at least two and probably more physicians would see the patient, each making a charge.

These facts must be made known to the general public and to young men who are entering medicine.

The picture of the family doctor as an unkempt old man who knows very little except how to appear benign is wrong. There were many and there are still a few such men. But, by and large, the family doctor of today is a well-trained medical scientist. And, what is even more important, he is an expert at the art of medicine.

This concept of the art of medicine is a subject that everybody talks about and nobody ever does anything about. Many medical students and not a few older doctors know much about disease and little about people. Such a man may fail in practice while the physician who knows much about people and little about disease may succeed. Surely, this in itself is an indication of the importance of human relationships in medical practice.

By the very nature of his work the family doctor has a better chance to ply this art of medicine. His knowledge of any individual under his care is likely to be much more nearly complete than that of his specialized colleagues.

The patient's disease and the Patient's problem are not always one and the same. It might be said that the disease is only one facet of the many-sided human problem which is presented to the physician. To repeat: the family doctor is the man in the best position to recognize and deal with this.

The small town family doctor of today can reasonably expect to have a well equipped small office and nearby hospital facilities. He can expect that, as his field of technical knowledge increases, he may bear more and more of the load of scientific medicine.

And, most important, as his knowledge of people increases he may hope to become the confidant of his community and an essential to it. His understanding and kindness — or, more scientifically, his psychosomatic ability — will be of prime importance to his community.

There is little of glory and much of hard work in being a family doctor. But there is also much of satisfaction and not a little of pride in assuming the position of family doctor to a group of people.

There are many trials in the practice of rural medicine. A large percent of these are put upon the family doctor by members of the profession. He may be looked down upon, his intelligence questioned, and he is many times treated cavalierly.

However, a definite trend exists to bring the family doctor to his rightful place in medicine. More and more recognition is being given to the man in general practice.

Training programs are now being aranged to give medical students more and more active

training in general practice. Existing programs are being enlarged.

Emphasis is swinging toward the man who does the majority of American medical practice. Such a trend promises benefit to patients and to medical practice as a whole.

—Paul Williamson, M.D.
University of Tennessee
Memphis General Practice Clinic

WALTER D. STEVENSON, 1883-1951

Walter D. Stevenson, who was President of the Illinois State Medical Society, 1949-1950, died suddenly in his home at Quincy, early Friday morning, October 26. An outstanding ophthalmologist for many years, Doctor Stevenson has been very active in the affairs of his county society and of the Illinois State Medical Society.

For a number of years he served as Secretary of the Adams County Medical Society, and in 1942 was elected Councilor of the Sixth Councilor District, serving in the State Society Council until his election as President Elect of the Illinois State Medical Society at the 1948 annual meeting. He was chairman of the Council for two years, 1946-48. At the 1949 Annual Meeting he was inducted into the office of President, and he gave a year of untiring service in this capacity.

Traveling all over the State of Illinois, he appeared before many county medical societies, and before many lay groups. He rarely refused an invitation to discuss the many current medical care problems which have been increasing in recent years. Doctor Stevenson was a member of many professional organizations, and an active participant in the many deliberations of these groups.

He was born in Baltimore, Maryland, October 28, 1883, receiving his education at St. Martin's Academy, and at Loyola University, Baltimore. He received his M. D. degree from the University of Maryland in 1906. He remained in Baltimore as an instructor in his medical school until 1909. Early in his professional career he decided to specialize in Ophthalmology, taking advantage of every opportunity to prepare himself for this specialty in medicine.

He became Oculist-in-chief at St. Mary's Hospital, Quincy, in 1914, which position he retained until his death. During World War I, he was a Captain in the Medical Corps, and was Chief Ophthalmologist for A. E. F. Base Hospital 54.

Doctor Stevenson was married to Alice Dorothy Greenlaw, October 8, 1910. He is survived by his widow, a son, Walter Stevenson Jr., who was associated in practice with his father, and two daughters, Mrs. Thomas Russell of Houston, Texas; the former Dorothy Stevenson, and Mrs. Hugh Black of Andrews, Texas; the former Jeanne Stevenson.

The 10,000 members of the Illinois State Medical Society extend their sympathy to Mrs. Stevenson and her family, for the loss of a husband and father who has served his nation, local community, and this Society faithfully over a long period of time.

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Malony, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



The Supply of Public Health Physicians

The problem of finding and keeping a sufficient supply of competent physicians in the field of Preventive Medicine and Public Health is one which needs to be faced and effectively solved by our profession.

It is generally agreed that many prospective public health men have chosen not to enter the field for these and other reasons: salaries have been low; medical schools have not made public health and preventive medicine, in a career sense, as attractive as is the care of patients or other branches of clinical medicine; employment by local, state or national government has not always yielded the degree of satisfaction from visible individual accomplishment which the physician has usually felt he receives from private practice. Often those with a natural flair for administrative-preventive-public health medicine have become engrossed in a busy private practice before such opportunities have been brought to their attention.

Illinois has need currently for a number of career men in the public health field in spite of the fact that it is one of the more fortunate states in respect to the number and professional quality of its public health physicians. There are open at present in Illinois at least one urban, four county, and four state positions for career men in the public health field, with salaries varying from approximately $6,000 to $9,500.

The physician who plans a career in public health — ideally has carried on successful private practice for one or more years; obtained a Master's Degree in Public Health during his first three years in the field; developed and maintained effective public relations as well as excellent human relations with the health department staff, individual physicians, and others. He should possess at least normal tact, patience and energy; secure and maintain the professional respect of physicians and others; be willing to work as many hours as necessary to accomplish the tasks at hand; be conversant with and adapt himself to sound administrative practices. If untrained and inexperienced, he should be young enough to make it reasonable for public money

to be used to assist with his specialized education; he should be interested in becoming certified by the American Board of Preventive Medicine and Public Health. The volume of work to be done in the normal public health department makes it important that the health officer be in excellent physical condition with stamina comparable to that of the private practitioner.

A physician desirous of entering the field can do so in a number of ways. He may select the career in medical school, thus aiming his academic activities toward proficiency in public health. He may select the specialty during internship or after a period of private practice. The Illinois Department of Public Health has contributed to the general knowledge of practical public health among medical students by arranging with cooperating full-time local health departments for three-month periods of field service for interested students. A few of these students will enter public health careers direct from internship or after varying periods of private practice. The Medical School of the University of Illinois is gradually building a School of Public Health, which will eventually provide facilities for graduate study necessary in specialization. The American Board of Preventive Medicine and Public Health provides for certification and is developing a list of approved Public Health residencies which will be published within a few months.

Public health physicians face their most difficult problems in areas where local physicians, individually or as a society, fail to support the public health man and the program of the health department. Other professions tend to line up fairly solidly behind their professional representatives in the public health departments. Medicine does this also in most instances, but the exceptions occur frequently enough that the public health physician in some localities finds his task a discouraging one. With cooperative relationships established, the position of the public health physician as health officer is marked by substantial satisfactions based on improved community health — which is also the result of effective medical service, sought earlier than normal by many as a sequel to cooperative public health activities.

The pressures of the National Emergency in no way alter the need for more public health physicians. In fact, the Emergency will almost assuredly underscore this need and its urgency. In peace, emergency, or war, the opportunities and need for the career physician in public health will increase. There is added satisfaction in the fact that salaries are aproaching reasonable levels.

Physicians who may be interested in learning more about the opportunities in public health in Illinois or in other parts of the country may obtain this information through Dr. Roland R. Cross, Director, Illinois Department of Public Health, Springfield.

THE CARE OF INDIVIDUALS, NOT HOSPITALS

To best fulfill this function, I would like to suggest that organized medicine (in Maine) working through each hospital medical staff and each county medical society, accept responsibility to acquaint its membership with costs of hospital services and of explaining hospital charges to patients. Obviously the facts and figures and the general pattern of hospital policy must be gotten through the administrator and the governing boards of these hospitals with whom there must be a close working relationship and mutual understanding of what is to be done and how to do it. I think it is only fair to say that the support and active assistance of the medical profession in this matter is of such vital importance to the entire community that if the administrator or the governing board of your hospital does not request the assistance of the medical staff, the staff should suggest offering its services to them. *Excerpt: Answering Hospital Cost Criticisms, Donald M. Rosenberger, Portland, Me., J. Me. M. A., Aug. 1951.*

CORRESPONDENCE



MEDICAL OFFICERS FOR U. S. AIR FORCE

Men and women practitioners in the medical profession and specialized vocations allied to medicine and surgery now have an opportunity to step directly from civil life into the ranks of commissioned officers in the United States Air Force, according to an announcement released by Lt. Colonel Charles D. Morat, Jr., Director of Personnel Procurement at headquarters of the First Air Force, Mitchel Air Force Base, N.Y.

The classifications from which officers are sought by the Air Force are: doctors of medicine, medical research and allied science specialists, physical and occupational therapists, medical supply and administration specialists, environmental and industrial hygiene engineering specialists, dietitians and nurses.

In each category, a definite set of educational and qualifying experience standards are required, with increasing professional attainment minima for progressively higher ranks. In all cases, degrees must have been granted by colleges and institutions acceptable to the surgeon general of the U.S. Air Force. For women, an age limit of 45 years has been established. While the commissions offered under this program are in the U.S. Air Reserve, applicants must be ready to be called to active duty at the discretion of the Air Force.

Because each classification has its own set of requirements for each grade from second lieutenant to the higher ranks, the First Air Force has set up clerical facilities for prompt servicing of all inquiries regarding these commissions. Men and women who are interested in any of the specified professions are invited to write to the Air Surgeon, Headquarters First Air Force, Mitchel Air Force Base, New York.

REIS IS SECRETARY

The National Federation of Obstetric-Gynecologic Societies has reconstituted itself as The American Academy of Obstetrics and Gynecology. This action was taken at the Federation meeting held on June 13, 1951 in Atlantic City in response to the long-felt need for a national society for obstetricians and gynecologists based on individual and personal membership.

The following officers were elected at this meeting: President — Woodard D. Beacham, New Orleans, Louisiana; President-Elect — Carl P. Huber, Indianapolis, Indiana; Vice-President — Louis H. Douglass, Baltimore, Maryland; Treasurer — Herbert E. Schmitz, Chicago, Illinois; Secretary — Ralph A. Reis, Chicago, Illinois; Executive Board — Robert G. Craig, San Francisco, California; John L. Parks, Washington, D. C.; Charles D. Kimball, Seattle, Washington; Samuel B. Kirkwood, Winchester, Mass. Philip F. Williams, Philadelphia, Pennsylvania.

The Academy was incorporated on August 4, 1951 as a non-profit corporation under the laws of the State of Illinois. Its objects are listed in the Constitution and By-Laws which were adopted at a meeting held at Hot Springs, Virginia, on September 5, 1951. They include "fostering and stimulating interest in obstetrics and gynecology and all aspects of the work for the welfare of women which properly come within the scope of obstetrics and gynecology."

The first business meeting of the Academy will be held at the time of the meeting of the American Congress on Obstetrics and Gynecology in Cincinnati, March 31 through April 4, 1952. The First Annual Clinical Meeting will be held in Chicago, Illinois, during the winter of 1952-53.

Applications for Fellowship may be obtained from the Secretary's office, 116 South Michigan Avenue, Chicago 3, Illinois.

INFERTILITY

The American Society for the Study of Sterility announces the opening of the 1952 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of one thousand dollars, and the essay will appear on the program of the 1952 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1952. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Massachusetts.

CLINICS FOR CRIPPLED CHILDREN FOR DECEMBER

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the December schedule of clinics for physically handicapped children. The Division will conduct 12 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. From private physicians, who are certified Board members, are selected the clinicians. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services:

The December clinics are:

December 5 — Joliet, Will Co. TB Sanitarium
December 5 — Alton, Alton Memorial Hospital
December 5 — Rock Island (Cerebral Palsy), St. Anthony's Hospital
December 6 — Macomb, St. Francis Hospital
December 11 — Peoria, St. Francis Hospital
December 11 — Christian Welfare, East St. Louis Clinic
December 12 — Hinsdale, Hinsdale Sanitarium
December 12 — Elgin, Sherman Hospital
December 13 — Springfield, St. John's Hospital
December 13 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
December 14 — Chicago Heights (Rheumatic Fever), St. James Hospital
December 18 — Peoria, St. Francis Hospital
December 18 — Effingham, (Rheumatic Fever), Douglas Township Building
December 19 — Springfield (Cerebral Palsy), Memorial Hospital
December 19 — Chicago Heights, St. James Hospital
December 20 — Normal, Brokaw Hospital
December 20 — Rockford, St. Anthony's Hospital
December 21 — Chicago Heights (Rheumatic Fever), St. James Hospital

RESIDENCIES IN ANESTHESIA

The Cook County Hospital wishes to announce that there have been two residencies established in the Department of Anesthesia effffective January 1, 1952. For further information communicate with the Medical Director of Cook County Hospital.

ORIGINAL ARTICLES



Diagnosis and Treatment of Meningitis

Archibald L. Hoyne, M.D.
Chicago

One might conclude that meningeal involvement should be recognized readily at any age and an exact diagnosis established by an examination of the cerebrospinal fluid. However it is well to remember that infants without neurological signs may have an extensive meningitis. Even over the anterior fontanelle there may be neither bulging nor tenseness. Consequently it is unlikely that a lumbar puncture will be made if meningitis is not suspected. But there may be other evidence to suggest the nature of the illness.

Among all varieties of meningitis, the meningococcic form is regarded generally as the most common. Therefore it should receive first consideration and a diagnosis often can be made on clinical signs before resort to the microscope. Nevertheless such a decision should be confirmed by laboratory findings. The first procedure is a careful inspection of the skin and also conjunctivae for the presence of petechiae which may be seen in 20 to 60% of the cases. The figures vary for different years. However, petechiae very seldom occur with any other kind of meningitis. If petechiae are found one of them can be punctured, a smear made and gram negative diplococci are often detected. In the event this examination is positive a lumbar puncture is not imperative. Nevertheless a blood culture should be secured and is generally positive for meningococci when petechiae exist. If there are no petechiae a spinal tap is a necessity for determining an accurate diagnosis. The cerebrospinal fluid should be cloudy and will probably have several thousand cells per cubic millimeter with a great preponderance of polymorphonuclears. A gram negative stain will generally disclose both extra and intra cellular organisms. A culture of the spinal fluid should also be obtained.

It may be well to mention that meningococcic infections when characterized by petechiae can be confused with other diseases in which skin lesions occur. Some of the conditions which one may be called upon to differentiate are: purpura, subacute bacterial endocarditis, chickenpox,

Presented before the General Assembly of the Illinois State Medical Society, Annual Meeting, May 24, 1951, Chicago.

Rocky Mountain spotted fever, smallpox, typhoid fever and drug eruptions. Arthritis occasionally is observed before there is evidence of meningeal irritation and then it may be thought that rheumatic fever is responsible for the illness. Sore throat also may be an early symptom.

Meningococcaemia may occur without meningitis and in some of these cases with extensive involvement of the skin there may be massive hemorrhages in the adrenals — the Waterhouse-Friderichsen syndrome.

Meningococcic infection may be witnessed at any time from early infancy to late in life. Our oldest patient at the County Contagious Hospital was 81 years.

Some time ago when the incidence of the pneumonias was much higher than at present it seemed that pneumococci as etiologic agents were often close contenders for first place[2] among the meningididies. However pneumococcic meningitis is by no means rare now. It may occur at all ages. An attack of pneumonia is not as frequent a precursor of the disease as one might expect. But a chronic otitis media is often found to be the focus of infection — especially in adults. This fact may offer a lead in considering the etiology of meningitis. Otitis media has been notably infrequent in our meningococcic patients and has seldom occurred as a complication.

For a number of years we have been impressed by the fact that so many patients with pneumococcic meningitis have a history of skull fracture on some remote occasion. Moreover, second attacks may occur and we have reported[3] an instance in which a man had four distinct repetitions. All four episodes took place within a period of five years.

There is nothing characteristic about the onset of pneumococcic meningitis to distinguish it from other varieties. Therefore a lumbar puncture must be made and the spinal fluid characteristics will be similar to those in the case of meningococcic meningitis except the organisms are gram positive. A culture should provide further confirmation of the diagnosis. A low cell count — less than a thousand per cubic millimeter — and large numbers of organisms usually foretell a bad prognosis. A reverse situation is much more favorable. A blood culture may also disclose the presence of pnemococci.

Staphylococcic[4] and also streptococcic meningitis are encountered far less often than the forms previously named. Although staphylococci may gain entry to the body by various routes, in our experience it has seemed that meningitis due to these organisms is most frequently associated with infections about the upper lip, or nasal sinuses. On the other hand ear infections in children particularly may afford the port of entry for streptococci. But the general decline[5] of all streptococcic infections is undoubtedly an important contributing factor in the diminished incidence of otitis media and lesser frequency of streptococcic meningitis. In order to establish an accurate diagnosis staphylococci or streptococci should be obtained by culture of the cerebrospinal fluid. In either instance a blood culture may also be positive.

Although the streptococcus viridans[6] is a rare invader of the meninges this organism in recent years seems to have increased its percentage as an etiologic factor among the streptococci.

Thus far an effort has been made to avoid enumerating all the common symptoms and signs of meningitis, which are so well known. But allusion has been made to the fact that an infant may have no neurologic evidence to suggest the existence of meningitis. Fever of unknown origin and anorexia may be the chief symptoms. With an undisclosed diagnosis it is well to keep in mind that the physical examination is not complete without a lumbar puncture. Then an examination of the cerebrospinal fluid may solve what seemed to be a perplexing problem.

Even beyond the age of infancy meningitis may occur when stiffness of the neck is not an early symptom and the kernig sign at the same time be absent. Reference is made here to Hemophilus influenzae infections. This organism, as we know, is a bacillus and is not to be confused with epidemic influenza a virus disease to which it is presumed to bear no relationship.

It is a matter of diagnostic significance that influenzal meningitis is very rarely observed in adults and that about 90% of all patients are under 5 years of age. The possibility of such an infection should always be considered in any meningitis patient who is less than 3 years old. This disease is sometimes initiated by a most

unusual feature. With an exceptionally abrupt onset and high fever of 104 to 106 the child develops an edema of the glottis without clinical signs of meningitis. In fact laryngeal diphtheria may be suspected or a foreign body in the air passages. Appropriate action must be taken without delay or there is a fatal termination as a result of asphyxiation. Moreover the inciting cause of death may not be considered. Furthermore in the average case of influenzal meningitis which has no alarming symptoms of impending suffocation an accurate diagnosis is not always made promptly, even though a lumbar puncture is performed. This is because early in the illness the cerebrospinal fluid is occasionally clear, the cell count within the hundreds and more important still lymphocytes predominate and no organisms are found. As a consequence of such circumstances and because of stiffness of the neck a diagnosis of nonparalytic poliomyelitis may seem probable. But the continuance of a high temperature and increased nucal rigidity calls for one or more additional spinal taps. Eventually the character of the cells in the spinal fluid will have changed from lymphocytes to polymorphonuclears and the influenzal bacillus probably will be discovered. In the meantime a blood culture may disclose the organism. If the patient is rational extreme irritability is often noticeable and seems to be a characteristic of this kind of meningitis.

In some years past it has been said that the tubercule bacillus accounted for more cases of meningitis than any other organism. Adults as well as infants and children contribute to the list. In many instances the clinical picture is strongly suggestive of the existing condition. It is the only form of meningitis in which an inequality of pupils is frequently observed. A facial palsy is also fairly common and the patient often stuporous. The spinal fluid is generally clear in appearance, the cell count is likely to range in the hundreds and nearly all are lymphocytes. The sugar content is almost certain to be low — perhaps less than 30 milligrams per cent. Nevertheless no organism may be disclosed in a smear even though the Levinson test is positive. While awaiting the results of the spinal fluid culture other diagnostic procedures should be conducted. A Mantoux test in the case of infants or young children and perhaps stomach washings will be helpful. An x-ray of the chest should always be made and a guinea pig inoculation with spinal fluid may afford the final proof desired. Although a convulsion may usher in any form of meningitis in infancy and childhood it is usually only the tuberculous that is apt to have a recurrence of convulsions after the disease is established. A prompt diagnosis is not always a simple matter. Poliomyelitis, various forms of encephalitis, brain abscess or brain tumor may deserve consideration. Rarely a diagnosis of leuetic meningitis is determined when a tuberculosis infection seemed probable and sometimes trichinosis or tetanus is mistaken for bacterial meningitis.

B. coli especially in early infancy and Fridlanders bacillus are organisms which are detected very seldom as etiologic factors in meningitis. Of course there are also other bacteria including gonococci which infrequently invade the meninges.

Treatment of meningitis no longer need be a complicated or laborious undertaking if modern methods[7] are adopted. Yet the ancient days of intrathecal treatment have been fading very slowly beyond the horizon of persistency, for many still cling to the needle for intra-spinal therapy. But fear in regard to the dangers of intracranial pressure has undoubtedly lessened greatly. Drainage is not necessary; nor are frequent lumbar punctures to permit examination of cerebrospinal fluid. We know that a low sugar in the spinal fluid may be expected to rise and a high cell count to decline as the patient improves. Is it not possible to tell by a physical examination including the appearance of the patient whether his progress is favorable or otherwise?

Even before a bacteriologic diagnosis has been firmly established it is justifiable to prescribe a sulfonamide. This action can be taken on the ground that a sulfa drug possesses as a rule some degree of effectivenes against any form of bacterial meningitis. Sulfadiazine is usually favored but not withstanding that sulfathiazole[8] is unpopular this latter drug, for the treatment of meningococcic infections, produces results equally as good or better. In addition haematura occurs more than three times as often with sulfadiazine. With the same dosages as for sulfadia-

zine blood levels for sulfathiazole are extremely low but the response to therapy is excellent. Sulfamerazine also gives satisfactory results. However it is possible that gantricin[9] because of its high solubility and perhaps the least likely of all the sulfonamides to produce cristyluria may prove to be best. Under any circumstances an adequate fluid intake of from 2000 to 3000 c.c. a day depending on the age of the patient is usually sufficient to prevent haematuria without the administration of an alkalae. A combination of sulfonamides may lessen the chances of kidney irritation.

Sulfonamide dosage is generally calculated on the basis of 1.5 to 2 grains per pound of body weight for each 24 hours. One half the total is then given for the initial treatment and the remainder divided into five equal parts, one of which is administered every four hours. Practically about 5 grams may be prescribed for the average adult for the first dose which is followed by 1 gram every four hours. For a child we usually give an initial dose of from 2 to 3 grams and then from 0.5 to 1 gram every four hours. For the initial dose it usually seems advisable to give a 5% solution of the sodium salt of the drug in 5% dextrose intravenously. This route may be continued using the drip method if the patient remains unconscious. Or the 24 hour dose may be divided in two equal parts and subcutaneous injections made twice daily. For the latter plan normal saline is sometimes preferable to the 5 per cent solution of dextrose. Blood levels for the drug should be obtained two to three times weekly, a daily check on the urine and a white blood count at least weekly.

For uncomplicated meningococcic infections penicillin does not seem to be an effective requirement although it is said that with a sulfonamide there is a synergistic action. Nevertheless it is well to know that massive doses of penicillin alone may be capable of promoting recovery. Aureomycin appears to be an efficient adjunct in some cases when progress has not been satisfactory. From 8 to 10 days sulfonamide therapy is usually sufficient for meningococcic infections.

Recently we have had some excellent results with terramycin for the treatment of meningococcic meningitis. The patients have ranged from 1 to 36 years. When this antibiotic is administered orally there seem to be no unpleasant reactions. For intravenous use there is some danger of thrombosis which occurred in the first two patients without serious affects. In accord with our usual plan the initial dose has been given by vein, generally 500 mg. To lessen the chance of thrombosis we have increased the dilution of terramycin, and now use 1 mg to 1 c.c. of physiological salt solution or preferably 5% dextrose. Following the intravenous administration, 250 mg were given orally every 6 hours for 6-7 days. There was no other medication. Insofar as I know these are the first meningitis patients to be treated with terramycin.

Penicillin is the outstanding remedy for pneumococcic meningitis. It should be given in massive doses. From 300 000 to 500 000 units may be prescribed every three hours if necessary. The initial dose should be injected intravenously and this same route may be followed until a good response is apparent. However satisfactory results can be obtained when injections are made in the muscle. It is advisable also to follow the line of therapy described for sulfonamide treatment of meningococci infections.

For either staphylococcic or streptococcic meningitis the plan of treatment is the same as for pneumococcic patients.

Hemophilus influenzal infections present special problems. Ordinarily there is the early age of the patient. Or as previously mentioned the onset is sometimes ushered in with edema of the glottis which calls for a prompt tracheotomy to preserve life. Selection of appropriate remedies is also of the utmost importance. In addition to sulfadiazine, streptomycin, dihydrostreptomycin, aureomycin or chloromycetin are available. It is possible that all of the last four are equally effective and the dosage for each will usually be the same. If streptomycin or dihydrostreptomycin is selected from 0.8 to 1 gram daily in divided doses at six hour intervals for a period of two days will often suffice. But even though the cerebrospinal fluid is sterile after 48 hours treatment with streptomycin the sulfadiazine should be continued for at least two weeks. When streptomycin or dihydrostreptomycin therapy is maintained for a week or more there is a much greater possibility of deafness occurring. Streptomycin or dihydrostreptomycin should be administered only by

the intramuscular route — never intravenously. On the other hand aureomycin can be injected in the vein, seems to have no untoward affect on the nerves of special sense and response to treatmet is equally satisfactory. However aureomycin sometimes causes nausea or diarrhea and rarely thrombosis.

It is a well known fact that streptomycin or dihydrostreptomycin are the chief agents available for combating tuberculous infections. For tuberculous meningitis it has been our custom to administer intramuscularly from one to two grams daily, injecting either gram 0.5 twice each 24 hours or double that amount depending on condition and age of the patient. We have continued such therapy for as long as 7 months without observing marked impairment of hearing. Some patients remain comatose or stuperous for weeks. During that time intravenous glucose 5% to 10% daily and finally feedings by stomach tube must be adopted. Good nursing care is also very important. Paraaminosalicylic acid (PAS) has been recommended quite highly but we have used it very little. It is likely to cause nausea and disturb digestion.

Sedatives are not often required for meningitis and morphine should not be prescribed. But restraints should always be applied until the patient is well on the road to recover.

CONCLUSION

Examination of cerebrospinal fluid is not a necessity for the diagnosis of every case of meningitis. The etiologic factor may be determined by a smear if petachiae are present or a blood culture may reveal the causative organism. The sole purpose of a lumbar puncture should be for diagnosis when other means are not adequate.

All therapeutic measures should be adopted for the welfare of the patient. Intrathecal treatment[10] is contraindicated for every form of meningitis. After a bacteriologic diagnosis has been established the cerebrospinal fluid generally requires no further thought.

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PENICILLIN AND ECTOPIC PREGNANCY

Among patients observed in private practice the incidence of ectopic pregnancy trebled after the advent of penicillin therapy in the treatment of chronic pelvic inflammatory disease. In seven of eleven cases of ectopic pregnancy in a two-year period, the patients had had penicillin therapy previously. A probable explanation is that in cases in which the fallopian tube is closed by inflammation, it reopens following penicillin therapy but, because of residual damage, the ovum may not descend to the uterine cavity and is impregnated in the tube. *Excerpt: Penicillin as an Etiologic Factor in Ectopic Pregnancy, Leon Krohn, M.D., Los Angeles, Calif. M., Sept.* 1951.

Acute Appendicitis

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Chicago

The statement "only an appendix" is indeed a dangerous one. Since this condition still accounts for over 5,000 deaths per year in this country alone, a revival of interest and a renewal of methods of attack surely seem warranted. In studying acute appendicitis for the past 15 years, both at Cook County Hospital and in private practice, certain specific ideas concerning the diagnosis and treatment have been formulated; these are presented.

In 1886, Reginald Heber Fitz of Harvard gave appendicitis its name. His description is considered one of the classics of medical literature. It is odd, however, that the condition was not discovered or described in the literature until such a late date. Anatomically the appendix was described in the sixteenth century; pathologically it was recognized in the eighteenth century; clinically it belongs to the nineteenth century; and therapeutically it is the challenge of the twentieth century.

PATHOLOGIC PHYSIOLOGY

In discussing inflammation and infection the late Richard Jaffe stated: "There is no infection without stasis." Thus, if a gallbladder can empty itself there will be no cholecystitis, if a sinus drains itself there will be no sinusitis, and if an appendix evacuates itself there will be no appendicitis.

Micro-organisms always are present, but as long as they are kept in motion they cannot increase in number and do not gain a foothold in the tissues; thus no inflammatory response results. Fecaliths, kinks, bands, spasms, mucosal folds, or foreign bodies might act as the obstructing factor and permit the bacteria to multiply. How far this inflammatory response will progress cannot be foretold. It depends upon the completeness of the obstruction, the virulence of the micro-organism and the resistance of the host.

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HISTORY AND SYMPTOMS

That certain types of people are predisposed to certain types of diseases cannot be denied. We know that the characteristic type for acute appendicitis is the young adult male. It is a disease which usually affects those in their teens and the second and third decades. There is no dogma in medicine, and although this disease may occur at any age, from the uterus to the grave, it becomes infrequent after the age of forty.

Any diffuse epigastric distress which localizes to the right lower quadrant within the first 24 to 48 hours is acute appendicitis until proved otherwise. Unfortunately, however, the patient does not use this terminology, but relates the same story in a different way. His terms for diffuse epigastric distress are: "belly-ache", "spoiled stomach", "cramps", or "gas". His usual remark is: "Something I ate gave a belly-ache." He oftimes heeds the advice of a well meaning friend who suggests a cathartic, and then some 24 hours later becomes concerned about a "sore spot" in the lower right side of his abdomen. It is at this time that he will usually consult the doctor.

The "two question test" suggests the diagnosis in well over 70 per cent of cases of acute appendicitis. Question number one: "Where was your pain when it started?" To this the patient usually points to his entire abdomen. Question number two: "Where does it hurt you now?" To this interrogation the patient usually points to the region of McBurney's point. This is one of the simplest, most efficacious and rapid methods of diagnosing a case of acute appendicitis.

Unfortunately nausea and vomiting have been taught as being frequent symptoms. This is not true. The majority of patients neither vomit nor complain of nausea; almost all however have anorexia. Anorexia, nausea and vomiting are really three degrees of one symptom, being dependent upon the degree of distention in the appendix. Vomiting is associated with

a markedly distended appendix, nausea with a moderately distended appendix, and since almost all acute appendices are associated with microscopic distention these patients should complain of anorexia. It is indeed a rarity to find a patient suffering with acute appendicitis stating that he is hungry.

Constipation is the rule, and diarrhea, the exception. Diarrhea, however, frequently is found in children suffering with acute appendicitis; if it is present in adults it suggests a pelvic appendix with an associated periproctitis.

PHYSICAL EXAMINATION

Under this heading one routinely includes temperature, pulse and respirations. A high initial fever strongly suggests some other condition but not acute appendicitis. The fever is usually of low grade in early appendicitis but as the disease progresses, especially after the first 24 to 48 hours, the fever begins to rise as the peritoneal cavity becomes soiled. One, therefore, should not wait for fever to develop since it indicates a complication rather than acute appendicitis per se. This rule does not apply to children, since they will develop a hyperpyrexia at the slightest provocation. The pulse is seldom of great diagnostic value. The so-called diagnostic ratio should be kept in mind, namely, that for every degree rise in temperature there is a ten beat increase in pulse. The respiratory rate is normal or roughly proportional to the fever; as peritoneal soiling progresses it increases. The patient with uncomplicated acute appendicitis usually does not appear to be seriously ill; in fact his appearance may be quite misleading as he walks into the doctor's office. Rarely have I found these patients lying in bed with right knee raised as is described so routinely in many textbooks.

To discuss the tremendous number of specific signs which have been associated with the diagnosis of this condition is not only exhaustive but exhausting; they have little or no practical value. To describe Bastedo's sign, Klemm's sign, Walkowitsch's sign, Reder's sign, Aaron's sign, Morris' sign, and many others too numerous to mention is only a display of academic muscle. Only those few signs, or tests, which are of practical value will be evaluated.

McBurney's Point.—This is the point of maximum tenderness as determined by the pressure of one finger. It is located in the following way: a line is drawn between the right anterior superior iliac spine and the umbilicus; this line is trisected. McBurney's point will be found where the lateral and middle thirds meet. A state of confusion seems to exist as to whether this point remains fixed regardless of the position of the appendix. Although it has been stated that the nerve endings of the eleventh and the twelfth dorsal segments are reflexely irritated by an inflamed appendix, practical experience suggests that the true point of tenderness is dependent upon the position of the appendix and not the fixed nerves.

Right Rectus Rigidity.—Increased tonus of the abdominal muscles, or so-called rectus rigidity, is not a sign of acute appendicitis, but rather a sign of peritonitis. We know that it is quite impossible to contract one rectus muscle without contracting the other. Why then do we refer to the sign as right rectus rigidity when both recti contract? To correctly test for this sign the examiner must place both of his hands on the abdomen, one on each rectus muscle. With gentle pressure he determines whether or not one rectus is rigid and the other relaxed. If such a condition exists and only one rectus muscle is found to be rigid, then this suggests a mass underlying the rigid rectus. Such masses in the case of acute appendicitis would be either a localizing inflammatory appendical mass made up of appendix, terminal ileum and omentum, or an appendical abscess. When both recti are rigid it denotes a muscular defense in response to an underlying peritonitis. Should such a rectus suddenly be released the patient will wince because of so-called rebound tenderness (Blumberg's sign).

Iliopsoas Sign.—This is not a diagnostic sign for acute appendicitis, but rather one which locates an inflamed appendix lying retrocecally and involving the fascia which covers the psoas muscle. It is conducted in the following way: the patient is placed on his left side and the right thigh is hyperextended (Figure 1). If pain over the appendical area is produced by this maneuver the test is considered positive.

Obturator Internus Sign.—This sign too locates an acutely inflamed appendix but does not diagnose it. It is performed by bending the knee and internally rotating the flexed thigh.



Figure 1. The Iliopsoas Sign.



Figure 2. The Obturator Sign.

This maneuver places the obturator internus muscle through its full range of movements and will cause hypogastric pain if an acutely inflamed appendix overlies its fascia (Figure 2). Pelvic inflammatory disease as well as an acute pelvic appendix can produce a positive obturator sign.

Rovsing's Sign.—This sign is considered positive when pain over McBurney's point is produced by exerting pressure over the descending colon (Figure 3). Supposedly it is due to a retrograde inflation of the cecum when colonic gas is forced from left to right in the presence of an inflamed appendix.

No physical examination is considered complete without a rectal or so-called bidigital examination. The latter is done, whenever possible, by placing the index finger in the vagina and the middle finger in the rectum. This will readily identify the cervix or adnexal pathology,

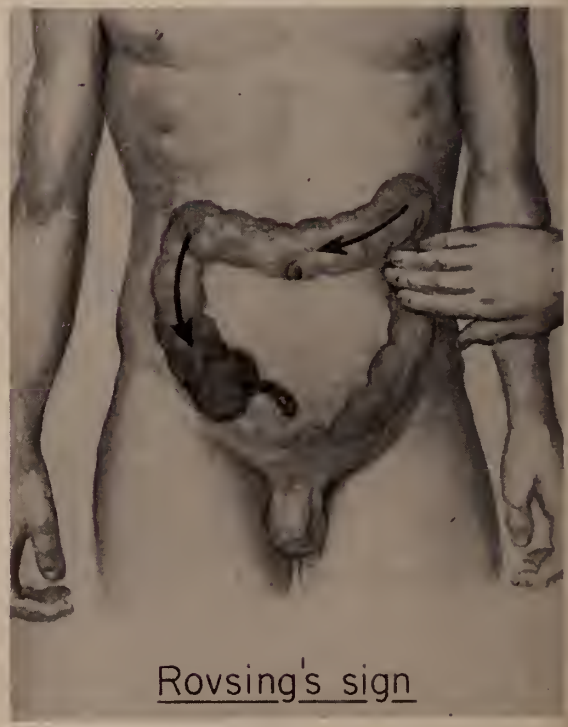


Figure 3. Rovsing's Sign.

a bulging cul-de-sac of Douglas, or fecal masses. Thus, greater orientation is obtained than is possible with a rectal or bimanual examination.

LABORATORY DATA

The laboratory data are helpful adjuncts in the diagnosis of acute appendicitis; however, they do not replace a carefully taken history and a well conducted physical examination. The differential blood count is at times more helpful than the total blood count, however, both of these are done routinely. Urinalysis is also a necessary procedure but may be misleading. If the inflamed appendix is located near or on the bladder, the ureter or the kidney, a few red cells may appear in the urine thus masking the picture. On the other hand, a rather large ureteral calculus may plug the ureter so thoroughly that no pus or blood can pass into the bladder and again the clinician is misled. Of late we have utilized a flat roentgenogram of the abdomen in those cases where the diagnosis is somewhat uncertain. Much work has been published recently regarding the isolation of fecaliths in the appendix as shown on stereoscopic views. This is helpful both in the direct and the differential diagnosis and should be kept in mind. There are numerous other laboratory tests which have been described, but these are of little or no practical value.

DIFFERENTIAL DIAGNOSIS

Although a tremendous number of diseases have been confused with acute appendicitis, for practical purposes, one must be thoroughly conversant with the usual conditions which cause the greatest diagnostic difficulties. The vast majority of our errors are found in the following five conditions: acute gallbladder disease, perforated peptic ulcer, renal colics, salpingitis and acute pancreatitis.

Acute gallbladder disease is more common after the age of forty. The gallbladder patient is usually the fair, fat and forty type of individual, with a history of selective dyspepsia and/or a previous similar attack. The pain is usually above the umbilicus and the tenderness is localized to the right upper quadrant of the abdomen. At times Head's zones of hyperesthesia will reveal the hyperesthetic area above the umbilicus and to the right, whereas such an area is found below the umbilicus in acute appendicitis. The pain is much more severe in acute cholecystitis and the patient usually requires sedation (this is most unusual in acute appendicitis).

Perforated peptic ulcer is almost always found in males. A history is elicited of a sudden dramatic attack of pain which doubled the patient up, forcing him to stop whatever he happened to be doing. Abdominal auscultation usually reveals a silent abdomen, and the roentgenogram demonstration of a spontaneous pneumoperitoneum is quite diagnostic. Tenderness is usually diffuse, the abdomen is board-like, the patient looks more ill, and shock may be present. The pin-point perforation of the forme fruste ulcer will present a misleading picture.

Renal colics may be caused by stones, uratic debris, microscopic thrombi or a dropped kidney with a Dietl's crises. The pain is usually in the loin, radiates along the course of the ureter, and then into the inner aspect of the thigh or the genitalia. A bradycardia is very characteristic of renal or ureteral colic. Tenderness over the kidney area is usually present. Red blood cells in the urine are most suggestive. In cases where great doubt exists emergency intravenous pyelography may provide the final answer.

Salpingitis usually occurs immediately before, during or after the menstrual period. It is extremely rare after the menopause. Tenderness is usually bilateral and over the region of the symphysis; on bimanual examination the tender tube may be felt; pain can be produced by moving the cervix. A positive cervical or urethral smear is pathognomonic.

Acute pancreatitis may be either the mild edematous type or the fulminating hemorrhagic type. The pain can be diffuse or it may be located in the back; in the latter case it is usually relieved by sitting up or lying prone. Shock is present early and the pain is extreme. A high blood amylase test corroborates the diagnosis.

TREATMENT

That the modern advances in chemotherapy have somewhat altered the treatment of acute appendicitis cannot be denied. Regardless of this fact, however, two schools of thought still exist. One group is of the opinion that acute appendicitis is a surgical condition whenever and wherever seen; the other group advocates conservative therapy in the so-called late or neglected case of acute appendicitis. A practical

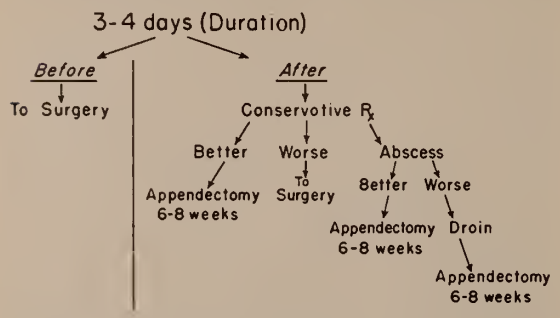


Figure 4. A Plan of Treatment for Acute Appendicitis.

middle of the road type of therapy can be applied which incorporates some of the tenets of both groups (Figure 4). It is always preferable to remove the leaking focus from the peritoneal cavity, however, there are times and situations when this cannot be accomplished.

A neglected so-called "3 or 4 day appendix" may be associated with a diffuse peritonitis or an early well defined appendical mass. In these two instances the mortality can be lowered if conservative therapy is instituted. Formerly, conservative therapy meant the Ochsner-Sherron regime, namely, Fowler's position, little or nothing by mouth, heat or cold to the right lower quadrant and sedation. Today, however, chemotherapy plays a major role; most cases receive penicillin for its effect upon the streptococci and staphylocci, and streptomycin which affects the gram negative rods. The sulfonamides, aureomycin and chloromycetin also have their advocates. Fowler's position has been discontinued in many clinics; I prefer to let the patient lie in any position in which he is most comfortable. The use of heat or cold over the right lower quadrant is purely a personal problem; either may be used since they act as counter-irritants which relieve pain, rather than having a direct bearing upon the appendical pathology per se. In the presence of gastric or small bowel distention gastric siphonage or intestinal intubation is indicated. Protein, carbohydrates, electrolyte, water and vitamin balance must be maintained. Plasma and blood are indicated at times. Sedation is necessary, however, full doses of morphine may mask the picture, hence, I prefer sedatives of a milder nature.

Under such a regime the neglected case of acute appendicitis will do one of three things: (1) get better, (2) get worse, or (3) form an abscess. There are many ways of determining whether a patient is getting better or worse, since changes in pain, distention, temperature, vomiting and abdominal sounds are all of diagnostic value. However, the one outstanding prognosticator is the pulse. A rule that I have followed and one which has served me well is the following: if the pulse increases twenty beats within an hour and continues to rise, surgical intervention is indicated. This should not be confused with a rapid pulse, in which case conservative therapy is still continued. The pulse is a more sensitive and more accurate indicator than all of the other signs.

If the condition should subside and the patient's condition improves, surgical intervention is delayed for 6 to 8 weeks. To attempt to do an appendectomy 8 to 10 days following a fulminating inflammatory process is to encourage wound infection, herniation, adhesions, fecal fistulae and intestinal obstruction. On the other hand, I feel that it takes approximately 6 weeks for the average inflammatory edema to disappear. If one waits during this interval and then has the patient return for an interval appendectomy the surgery is simple technically, and the postoperative course is usually uneventful. That the patient might have another attack within this waiting interval is possible but most improbable.

If, under conservative treatment, the patient gets worse, the surgeon is forced to operate; these are the cases which are associated with a high mortality. Surgical intervention is considered in the hope that the leaking appendix might be removed. However, these late neglected appendices are usually necrotic and oftimes cannot be removed; if removal is possible it may have to be done by morcellation. The question as to whether drainage is correct or incorrect in such a case is still controversial. I lean toward the school of thought which believes that the peritoneal cavity is only a potential cavity, and therefore cannot be drained. It has been my custom, therefore, to close these abdomens without drainage.

The third possibility under conservative treatment for the neglected case of appendicitis is the formation of an appendical abscess. This is suspected when the patient presents a spiking type of fever, chills, sweats and a leukocyte count over 20,000. Should such an abscess form it may get

better or it may get worse. If resorption takes place and the inflammatory mass diminishes in size the patient's condition will improve and the mass will disappear. Such a patient is permitted to leave the hospital and is advised to return in 6 to 8 weeks for an interval appendectomy. If, however, the mass enlarges and the patient's condition gets worse the abscess is incised and drained. If the appendix is found in the abscess cavity (this is most unusual) it is removed; if it is not found, an interval appendectomy is performed 6 to 8 weeks after drainage of the appendical abscess. Auto-appendectomies have been reported, but these too are quite infrequent.

This plan does not apply to children suffering with acute appendicitis, since it has been shown that children do not have the ability to localize acute appendical lesions. Therefore, in children, the rule must be followed that the case is a surgical one regardless of the time element.

TECHNICAL ASPECTS OF APPENDECTOMY

The choice of the incision, whether a McBurney or a rectus, will be determined by the type of case and the surgeon's preference. To spend a great deal of time locating the appendix can cause much embarrassment to the surgeon and postoperative discomfiture to the patient. Congenital absence of the appendix is indeed a rarity since this has been estimated to be present in one cut of every 100,000 individuals.

At times it might be difficult to locate the appendix, however, by following two simple maneuvers the vast majority of appendices can be found readily (Figure 5). The cecum is picked up in a moist laparotomy sponge and gently pulled upward toward the anesthetist. The terminal ileal fat pad (a neglected bit of anatomy which is an excellent surgical guide) is grasped with a Babcock forceps and handed to the assistant at the opposite side of the table. These two simple maneuvers will result in bringing the appendix immediately into view in 85 to 90 per cent of cases. Since over 70 per cent of appendices normally lie retrocecally and since the terminal ileum and its fat pad run parallel with the cecum the rationale of these two maneuvers is apparent.

The anatomy of the appendical artery should be emphasized if the serious complication of intra-operative hemorrhage is to be avoided

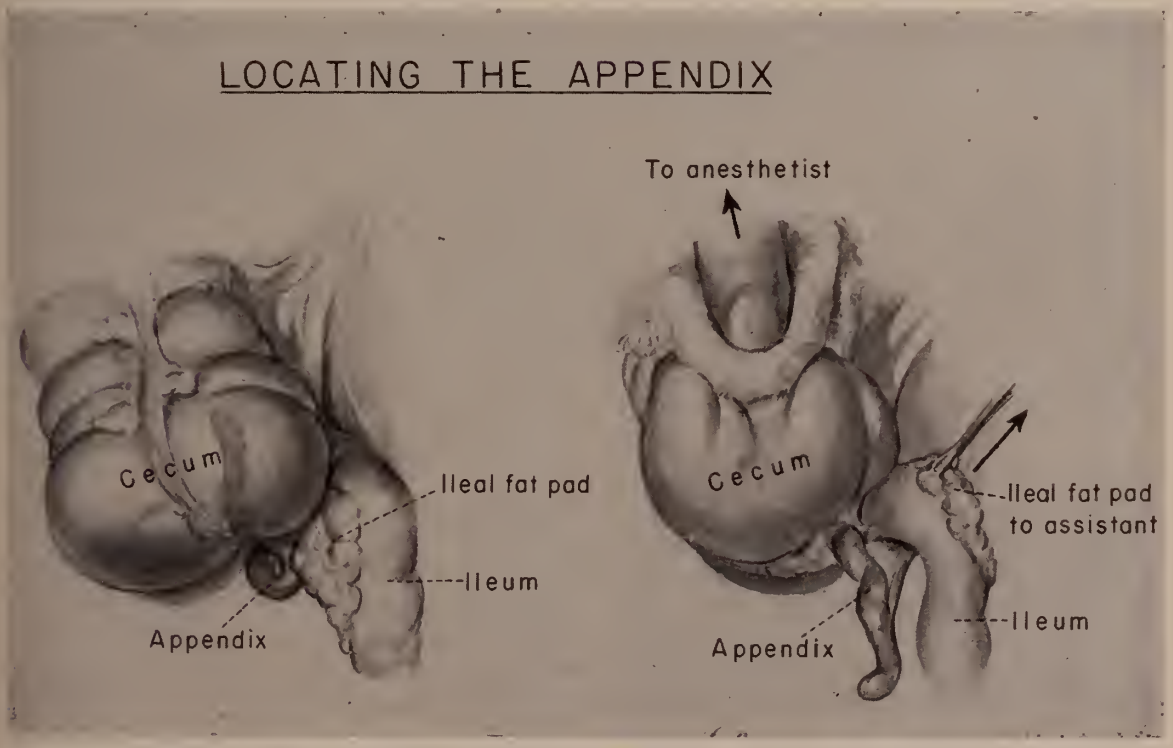


Figure 5. Surgical Anatomy as an Aid in Locating the Appendix. The appendix is placed retrocecally in over 70 per cent of individuals. The terminal ileum, as it leaves the pelvis to join the cecum, runs parallel with the cecum and not at right angles to it. The terminal ileal fat pad usually hides the appendix.

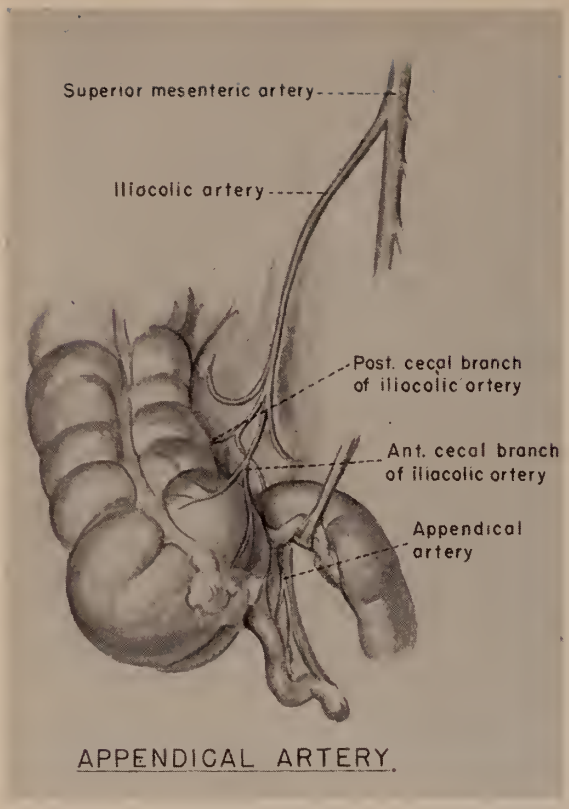


Figure 6. The Surgical Anatomy of the Appendical Artery. The appendical artery passes retro-ileally and not retrocecally.

(Figure 6). The appendical artery arises from the posterior cecal branch of the ileocolic artery. The artery to the appendix does not pass retrocecally, but takes a retro-ileal course. If, therefore, hemorrhage from a slipped appendical artery should take place during the course of an appendectomy the ileal fat pad should be raised and the bleeding point searched for behind the terminal ileum. A retrocecal search for such a bleeding vessel will fail to reveal the source of hemorrhage.

Many methods of management of the appendical stump have been described, these too must remain a personal problem until definite evidence can be produced to substantiate the claim that one method is definitely superior to all the others.

SUMMARY

1. The mortality of acute appendicitis still remains high.

2. The "two question test" has been useful in correctly diagnosing most cases of acute appendicitis.

3. The fallacy of right rectus rigidity as a diagnostic sign is discussed.

4. The iliopsoas and obturator signs are stressed as signs which locate rather than diagnose an acute appendicitis.

5. A simple method of locating the appendix is described.

6. A plan of treatment is presented which includes the management of both the early and the neglected case.

25 E. Washington Street

EDEMA FOLLOWING MASTECTOMY

There is a critical period following radical mastectomy when chronic induration of the corresponding extremity may develop. If swelling can be eliminated during this period, no enlargement or induration of the extremity will occur. The use of a continuous compression bandage to the arm for an eight-week postoperative period is recorded in 50 patients. In no case where the bandage was properly used did clinical edema of the arm develop. It is concluded that the routine prophylactic bandaging of the arm is an excellent preventive of chronic indurated upper extremity following radical mastectomy. *Excerpt: The Prevention of Lymphedema of the Upper Extremity After Radical Mastectomy, Joe M. Parker, M.D., Oklahoma City, Okla., The Amer. Surg., Sept. 1951.*

Obstetric Helps

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I shall endeavor not to take undue advantage of the implied comprehensiveness of my subject, but will stress briefly a goodly number of what I consider practical aids in the all important field of obstetrics. Much of what I shall have to say will not border on the scientific, and no doubt will be rated as quite common place. Nevertheless, I hope each of you will find at least a few pointers you will want to carry back with you to your practice.

I shall begin with the statement, *"Every female child should be considered a potential mother."* The obstetrical millennium will not come to pass until this worthy consideration is extended her; and this not only by the profession alone, but by society at large. She is to be protected to the fullest extent by all health measures, including ample intake of vitamins A, C, and D; elimination of focal infections; and protection against those infectious diseases that reflect unfavorably during the child-bearing period.

In that rebella contracted during pregnancy, particularly during the first three months, is associated with a high incidence of fetal malformations, the female child, at least until a reliable vaccine is developed, should be designedly exposed to that contagion. The United States' incident rate of the first trimester, 27 per cent, has never run as high as the corresponding rate, 90 per cent, reported from one of the original Australian series. There seems to be little ground for the routine termination of such pregnancies as advocated by some. Personally, I question whether such a procedure is ever justified, in that medicine even in its most modern state has never gone all out for eugenics to the extent that we should destroy our unborn even though it involved the possibility of the destruction of those normally formed.

The teaching of sex hygiene in our public schools should be replaced by the more important goal, *healthy parenthood*; the former to be emphasized only as a means to that end. Every individual has a natural desire to become a healthy parent, and we should give all possible assistance to that desire. The physiology and some pathology of human reproduction should be included in the senior high school curriculum. This would lead to an increased general interest in prenatal and parturitional care. Besides, it is all wrong to prepare a girl for life by overemphasizing preparation for a classic career at the expense of a basic understanding of that most vital function for which she was primarily created, namely, reproduction. Hes physical design and certain correlated functions all but scream out the priority of that function.

Preconception examination should be routine. The increasing number of women, particularly those contemplating marriage, who come to their physician seeking such an examination, is quite convincing that we are living in a better day.

PRENATAL CARE

Prenatal examination should be thorough and adequate, and should include the following, —

1. A relevant family and past personal history.
2. Examination of teeth, tonsils, heart and lungs.
3. Checking of blood pressure and urine.
4. A careful taking of the pelvic measurements.
5. Checking the Wassermann, Rh factor, and hemoglobin.

Since most patients consider pelvic measurements the most important part of a prenatal examination, for the sake of their mental satisfaction it is good policy to take these measurements at the first visit.

Outlet pelvimetry is more important than *inlet pelvimetry*. It is at the outlet that most delivery difficulties arise; most labors are arrested; over 90 per cent of forcep operations are indicated; most permanent and fatal injuries to the infant occur — especially at breech births; and the mother suffers practically all of her immediate and most of her permanent birth damages.

The least an attendant can do is to estimate the bis-ischial diameter by passing his gloved

Presented before the General Assembly, Illinois Medical Society, 110th Annual Meeting, Springfield, May 23, 1950.

fist transversely between the tuberositics. An outlet admitting an 8 cm. fist will permit the birth of a 7 pound baby.

External inlet measurements are indirect, inaccurate, and of little value except to classify the type of pelvis, and are soon to be omitted from some leading standard textbooks.

The only real pelvimeter, the baby's head, can be readily applied to the inlet either manually or by test of labor, but not to the outlet until late in labor, which may be too late.

X-ray pelvimetry is well indicated in all cases where the architecture of a pelvis is questionable as to diameters and available capacity.

Erythroblastosis kills more babies than does syphilis, and for that reason checking of the Rh is more important than the taking of the Wassermann.

Although one of the most important and intriguing discoveries in the last half century, the Rh factor is frequently very disturbing to many expectant parents. Those parents, where the father is Rh positive and the mother Rh negative, should be informed that the first baby is very, very rarely affected, and that no more than one Rh negative mother in 30 will have an erythroblastotic baby in any pregnancy, and that in general 50 per cent of the affected babies live.

The only treatment for the infant is blood transfusion. The best results are obtained with compatible Rh-negative female blood — not the mother's blood. All babies erythroblastotic from the Rh factor should be transfused immediately after birth, preferably by the replacement method. A much lower incidence of mental retardation and brain damage follows from this technic than from the simple method. The degree of cerebral damage does not depend upon the degree of the erythroblastic manifestations.

Rh antibody titrations of Rh-negative expectant mothers should be routine.

Erythroblastosis *per se* is not an indication for induction of premature labor or caesarean section. Neither does the Rh-negative factor indicate therapeutic abortion or sterilization. If the husband is homozygous, barring legal complications, insemination may be justified.

All females below the menopause age, adults, children and infants, should have a serologic check on the Rh factor that they may be forewarned and protected against a transfusion with Rh-positive blood, and have their child bearing possibly foiled, and perhaps their own life jeopardized.

An Rh-negative donor list should be established at all hospitals.

Twelve per cent of all pregnancy patients are anemic. The hemoglobin, (or better still, the hematocrit, should be checked at the first visit, at six months, at term, and six weeks postpartum:

A hemoglobin of 9 mg. or less warrants a blood transfusion.

The prenatal patient should be seen at least every 4 weeks up to the end of the sixth month, every two weeks during the seventh and eighth months, and every week during the last or ninth month.

The *blood pressure* and *urine* examinations should be taken and carefully recorded at each visit.

The blood pressure apparatus is the most important of all prenatal equipment. Its usefulness is not limited only to hypertension complications, but is equally valuable in handling cases of cardiac disease. Regardless of what and how many murmurs a heart may present, we are not specially disturbed so long as the pressure is maintained at 120 over 80. However, we do lend closer vigilance.

A diagnosis of nephritis or toxemia during pregnancy or the puerperium should not be made solely on the basis of albumin present in a voided specimen. This custom often extends unnecessary anxiety and needless therapy to the patient.

Likewise, the attendant upon finding sugar in the urine, should not upset the tranquility of the patient and her family by informing her she has diabetes in addition to her pregnancy, at least not until he has ruled out lactosuria or has taken repreated fasting blood sugars. We must not forget that glycosuria in the early weeks of pregnancy is usually physiologic.

In supervising the prenatal patient the possibility of toxemia and placenta previa should be kept ever in mind — particularly during the last trimester. The mortalities from these two complications can be most effectively combated, not at the time of delivery, but during the prenatal period. Indeed, they afford the greatest excuse for prenatal supervision.

As a prenatal patient sits before her physician in his office, it should occur to him, "Madam,

you are a candidate for two possible catastrophies, eclampsia and placenta previa." With this in mind, he is duty bound to question her at each visit as follows, "Mrs. 'Jones,' since your last visit, have you had any nausea or vomiting?" "Have you had any dizziness?" "Have you had any vertex headache?" "Have you had any insomnia or sleeplessness?" "Have you had any blurred vision?" "Have you had any morning swelling of the face?" "Have you had an epigastric or upper abdominal pain?" "Have you had any spotting of blood or bleeding from the vagina?" Not until he has a negative answer to each of these questions, and has found the blood pressure and urine to be normal, has he exhausted his responsibility to the patient, nor can he say, even to himself, "Mrs. 'Jones', you are in no immediate danger.

May we interject: *Evening edema of the lower extremities is usually physiologic, while morning edema of the face is usually pathologic.*

A normal systolic pressure rising to 140 or 160 mm of mercury, with or without albuminuria or subjective symptoms, means *hospitalization.* A raising and sustained diastolic is equally, if not more, significant; and the younger the patient, the greater the significance. Likewise, there should be hospitalization of all cases of painless, causeless bleeding in the last trimester. There should be no rectals, vaginal, or packing in the home. If a blood bank is not available, donors should be taken along, or better, they should be sent on ahead that they may have their blood typed and checked for the Rh as soon as possible.

The *diet of the prenatal patient* should not be restricted except when an abnormal weight gain is constant, or some systemic complication arises. We are all familiar with the expression, "Doctor, I eat like a horse." Particularly do we hear this during the second trimester. This sudden increased demand for food, as experienced by the majority of patients, leads one to believe that Nature in a protective mood is trying to overcome some heretofore bodily deficiences. Accordingly, I let my patients eat, knowing that the size of the baby will not be affected; that eating is one of the few pleasures of the expectant mother; and that in the majority of cases the demanding appetite will have only a temporary "run".

The annoying and frequently very distressing symptom of *hyperemesis gravidarium* is often treated too casually and inconsiderately by the attendant.

At the very certain risk of being criticized as ultra *passé,* I, from my experience of more than two and one-half decades, empirically recommend so common a drug as luminal sodium, given intramuscularly in the gluteal muscle of a dosage from 2 to 5 grs. The average case requires but a single administration every 2 to 7 days. The preparation is put up in powder form in ampules by the Winthrop Chemical Company. Down through the years I have run the gauntlet of using the various hormones and vitamines, and more recently the combination of pyrodoxine and suprarenal cortex. In our hands, especially in ambulatory cases, none has given the satisfactory results as luminal sodium. Its closest, but only fair, competitor has been oral draminine in 50 mg. doses, taken one-half hour A.C. one to three times daily as needed.

Another gratifying service to the expectant mother, especially after the sixth month, is the *maternity corset,* which in a true sense is an abdominal support. Were the husband to have an abdominal tumor of a similar size, he would quickly welcome such a garment.

A properly fitted maternity corset reduces the incidence of striae gravidarum, relieves the fatigue of the erector spinae muscles, lessens the discomfort of the softened sacro-iliac and symphysis joints, improves the body lines for dress appearance, and eliminates the need for the undesirable feature of round garters or rolling of the stockings.

In our practice we have found it most practical to have the garment fitted in our office by our experienced nurse. We also do the subsequent adjustments.

A *layette pamphlet,* given to the patient at her first visit, is an appreciated service, especially by the primiparous patient. The pamphlet, in addition to listing layette articles and naming the various stores from which they can be purchased, should include pertinent information and instructions for the mother as to her diet, clothing, exercise, personal hygiene, abnormal symptoms, schedule for routine visits, the doctor's office hours and phone numbers, and signs of beginning labor. It is, also, helpful to include a separate list of articles such as nursing bottles, nipples, baby powder, hot water bottle, bath thermometer, etc.; all to be available in one package

at some local drug store. The package, which may be ordered as the "Infant Package", eliminates considerable petty shopping on the part of the patient.

Another minor, but very practical service, is supplying each patient with an *appointment slip or folder,* indicating the date and hour of the next appointment. This eliminates much forgetfulness on the part of the patient, keeps appointments running more smoothly, and eliminates much unnecessary phoning by the receptionist.

Being ever alert for breech presentation, transverse-lie, and multiple pregnancy, the competent attendant will practice careful abdominal palpation at every visit after the seventh month. In all cases of either of these suspected diagnoses, he will seek the aid of the X-ray. In the case of breech it will confirm the diagnosis, identify the variety of the presentation, disclose deflection attitudes, and reveal the occasional unsuspected and frequently associated pelvic contration.

A virtual proof of breech presentation can be achieved by applying *Mengert's maneuver.* This is performed by steading the breech with one hand while slowly, firmly, and steadily compressing the fetal head with the fingers and thumb of the other. The resulting pressure produces a marked slowing of the fetal heart rate from 140 to less than 100 beats per minute. A similar pressure to the breech produces no alteration in the fetal heart rate.

Since the fetal mortality of the breech presentation is three to five times that of the cephalic, and that of the neglected transverse-lie is 100 per cent, it is quite mandatory these two mal-presentations be promptly corrected. With all conditions favorable, this is accomplished by external version, and is done with greater ease and more success from the thirtieth to the thirty-sixth week. The later in pregnancy the operation is performed, the greater is the need for anaesthia, preferably surgically deep ether, and the greater the number of failures.

Efficient prenatal care is as important as efficient delivery care.

All labor cases should be hospitalized. If it is important that father go to the hospital to have his tonsils removed, and it is, then it is more important that mother go to the hospital to give birth to his offspring. By all means this applies to all previous section cases, breech, transverse-lie, and chin posterior presentations; and those cases of placenta previa, abruptio placentae, and contracted or border-line pelvis, and cases complicated by cardiac, pulmonary, and nephritic diseases.

CONDUCT OF LABOR

Analgesia in labor is here to stay, and anyone attempting the practice of obstetrics in a modern community, should first be well trained in the use of one or more of the present day methods.

A most important feature in the conduct of labor is *checking and recording the fetal heart* rate *at regular intervals* — every 30 minutes during the first stage; every 15 minutes during the second stage; and oftener as the moment of birth approaches.

The more closely this routine is observed, the greater is the number of salvaged babies.

Let us be ever reminded that the obstetrical patient differs from the medical or surgical case in that it extends us the responsibility for two individuals, and that the stethoscope is our chief aid in checking the well-being of the one unseen.

Pelvic examinations should be made rectally. However, in the case of delayed progress in labor, or some irregular presenting part is discerned by rectal, or when determining the diagnosis of placenta previa, then, by all means, should the vaginal be utilized.

CONDUCT OF DELIVERY

1. *For the sake of asepsis,* the patient should not be taken to the delivery room longer than one-half hour before the expected time of delivery. A much longer period is quite certain to lead to contamination. It is difficult to prevent perspiration, amniotic and fecal fluids from conveying in time bacteria through the draping materials — as well as the problem of keeping the drapes from becoming awry. Likewise, there is the likelihood of contamination of the instruments from prolonged exposure; and, also, the difficulty of controlling of non-sterile contacts by the assistants, when subjected to tiresome waiting.

In such instances redraping and replacing of gowns and gloves should be a usual routine. In other words, the spirit of Semmelweis should ever prevail.

2. In general, one should follow the slogan, *"If a perineum exists, an episiotomy should be*

done." Unless apt at repairing third degree lacerations, one should go slow in adopting the routine median. It is better to guide the baby beside the rectum rather than through it.

An outstanding goal of every delivery is an intact sphincter and a nulliparous introitus. A timely episiotomy and a proper repair will guarantee both. *In repairing a perineum, one should always preserve its expression.*

3. When delivering a premature infant one should adhere closely to the dictum, *"The more premature the infant, the more generous the episiotomy."* It is here an episiotomy is often a life-saving measure. Fully 50 per cent of all premature infant deaths are due to intracranial hemorrhage. This results from injury to the frail blood vessels born by the delicate brain-supporting structures, and is in direct proportion to the degree of moulding.

4. In repairing episiotomies and perineal lacerations, one should avoid *too many, too tight, too hard, and too haphazardly placed sutures.* When the patient's limbs are taken down from the leg-holders, all the perineal structures that have been injured fall into normal relation, and all that is necessary in their repair is to gently coapt their respective margins for the brief period of ten days. By that time Nature will have taken over.

5. Conditions being favorable as to skill and surroundings, the *prophylactic forceps* is an operation strongly recommended. It spares the mother the most exhausting hours of her labor, and the infant, prolonged cerebral compression.

6. In the conduct of the third stage the blood loss should be checked as much as possible. *It is simpler to conserve blood than it is to transfuse it.* It is here we depend much upon the use of oxytocics.

Either of the following methods is highly practical:

(a) Five tenths to 1.0 cc of pituitrin is given hypodermically following the birth of the baby, and one ampule of ergotrate (gr. 1/320) hypodermically after the birth of the placenta.

(b) The Chicago Lying-in technic. After a delay of 30 seconds following the birth of the head and the assured birth of the shoulders, 1 cc of ergotrate (gr. 1/130) is administered intravenously.

We prefer and routinely employ this latter method. In practically all instances the blood loss from the uterus is less than that from the episiotomy. We further find it eliminates the need for the administration of some ergot preparation during the first two or three postpartum days as customarily done for the prevention of subinvolution of the uterus. It thus reduces both medication to the patient and service by the nurse.

(The ice-bag to the fundus has rightfully, long since become *passé*. Not only is its efficiency questionable, but it serves as an added chore to both the nurse and the patient. Besides, 18 (??) per cent of them leak.)

PUERPERAL CARE OF MOTHER

1. The long standing, dogmatic dictum, "Pituitrin is a criminal agent if administered before the birth of the child", has until recently held us in abeyance in developing the fullest utilization of this oxytocic. However, as with the mastering of strychnine as a useful drug, we have developed its administration and regulated its dosage to a degree that it is now not only a safe, but a most important aid in handling such problems as induction of labor, inertia uteri. postpartum hemorrhage, and abruptio placentae.

The *intravenous drip technic* is more physiologic than the intramuscular and intranasal methods, and for that reason is safer and more efficient. Since *pitocin,* perhaps not quite as efficacious as pituitrin, reduces pituitary shock and eliminates the danger of blood pressure elevation in unrecognized preelamptic patients, it is the better choice of the two preparations.

Technic of Intravenous Pitocin Drip for the induction of labor and treatment of inertia uteri:

(1) Mix 5.0 m. of pitocin thoroughly with 500 cc 5 per cent glucose solution. (50 cc of solution is equivalent to 0.5 m. of pitocin.)

(2) For the first half hour administer with a pre-tested Murphy drip apparatus 0.25 m. of pitocin — 12 to 14 drops of the solution per minute — .8 cc of solution.

(3) After the first half hour, if .25 m. is not effective, increase to 0.5 m. of pitocin over 30 minutes — 25 to 30 drops of the solution — 1.7 cc of solution.

Precautions:

(1) Do not have the solution flowing when the needle is inserted — a dangerous amount of the pitocin might be given before the flow is

regulated. The number of drops should be built up from zero.

(2) The patient should never be left alone. The flow must be checked from time to time. Moreover, the clamp might slip.

(3) The uterine contractions must be observed constantly. If they exceed 2 minutes or if the fetal heart tones show abnormal variation, the clamp must be shut off immediately and remain shut until the disturbances are corrected. In the meantime a normal salt solution by means of a Y-tube may be switched for the pitocin solution.

These precautions must be observed unrelentingly. A pituitary oxytocic unscrupulously administered intravenously can be "dynamite".

The greatest use of *pitocin drip* is the treatment of postpartum hemorrhage. Eastman reports he has successfully substituted it for the intrauterine packing in treating uterine hemorrhage in their last 12,000 delivery cases. In dealing with this complication, the rate of flow may be increased to 60 or 70 drops per minute if indicated.

It appears pitocin drip is destined to replace the intramuscular use of pitocin and pituitrin, as it can be advantageously employed, also, in incomplete and septic abortions, some cases of hydatiform male, certain cases of abruptio placentae, and following the birth of the baby at caesarean section.

2. An abdominal binder for the first two or three postpartum days is gratefully accepted by the patient. This is ordered for her *comfort* only, and not as a prophylactic against hemorrhage or as an aid for figure restoration. The uterus following delivery weighs 2 pounds, and its supporting structures are extraordinarily lax, and the abdominal wall extremely flacid. The supporting effect of the binder gives real comfort.

3. The patient is entitled to and will tolerate *a regular diet* as soon as she has recovered from her labor and anaesthetic. Her many hours of exhaustive labor should extend her the same consideration given the gridion star, whose meal following one hour of many times less physical expenditure includes a one and one-half inch steak. Her digestive tract and forces have not been disturbed, and it would appear to be an injustice to limit her to a sloppy and soft food diet the first 24 to 48 hours after delivery, a routine frequently observed.

4. Most patients can be relieved of *perineal pain* by removing the vulvar pad and applying an ice-collar covered with a sterile towel. Heat from a light bulb, also, serves well.

5. The *engorgement of breasts* is readily relieved by oral stilbestrol — 1 to 2 mg. taken t.i.d. for 2 or 3 days. If it is desired to dry up the breasts, the dosage is increased to 5 to 10 mg. t.i.d. for 3 or 4 days.

A properly applied *adhesive support, not binder,* can also be used in the treatment of engorgement. It gives complete relief, and has the advantages over the soft material supports of being completely efficient, not having to be changed at nursing time, being more comfortable, and allowing easy access to the nipples for nursing.

6. The patient can profit greatly by exercises during the puerperium, and some such routine as the following should be prescribed:

a. First day and after: Lie on stomach ½ hour or longer t.i.d. This replaces the awkward and embarrassing knee-chest position.
b. Second day and after: Raise one foot then the other with the knee straight toward the ceiling 10 to 12 times night and morning. Sit on the edge of the bed and dangle feet 5 to 10 minutes 2 or 3 times daily.
c. Third day and after: With arms folded high across the chest, rise rapidly to upright sitting position and recline slowly 10 to 12 times night and morning following limb exercise, "b".

The patient should continue lying some on stomach during the day or during sleep, and the sitting-up exercise, "c", for one month after leaving the hospital.

7. As we retrospect through the years there arises an inner penance for the disservice we rendered our loyal patients who so faithfully accepted our orders to remain in bed 10, 12, 14 or more postpartum days. This late rising delayed their convalescence, and often so because of unnecessary complications resulting therefrom.

Early rising is now commonly conceded to have the following advantages, —

a. An increased sense of physical well-being and a better psychological attitude.
b. A reduced incidence in such complications as cystitis, respiratory infections, thrombophlebitis, and pulmonary embolism.
c. A more rapid involution of the uterus.

d. An economic saving because of a briefer hospital stay, and

e. A shorter convalescence period.

Routines of early rising vary in different clinics. Ours is as follows, —

a. Second day; Up in chair 15 minutes 2 times.

b. Third day: About room 30 minutes 2 to 3 times and to the toilet.

c. Fourth day: Up and down corridor.

d. Fifth day: Shower bath.

e. Sixth day: Privilege of washing hair.

The daily exercises listed above are conducted in conjunction with these early rising privileges.

Although early rising may enable a patient to leave the hospital as early as the 5th day, it is preferable that she not do so before the 8th or 10th day. She is well entitled to the extra days of hospital rest.

CARE OF THE INFANT DURING THE PUERPERIUM

1. The first service to the infant is thorough aspiration of its nasal and bronchial passages. This is to be done before any stimulation of respiration. The nares and mouth can be aspirated with a 4-ounce soft rubber ear syringe as soon as the head is born. Immediately following the cutting and ligating the cord, the trachae should be freed of mucous with a soft rubber catheter.

Aspiration of caesarean born babies should be routine, since it has been found their bronchial tree contains on the average of 6 to 8 cc of mucous, which is three times the average found in babies born per vaginum. No doubt this fact accounts for many of the unexplained deaths that occur shortly after birth among babies delivered by section.

All apneic babies are to be given oxygen.

2. The care of the infant in the majority of cases, at least until the pediatrician or family physician takes over, becomes the responsibility of the obstetric attendant.

We put the baby to the breast 12 hours after birth. This is done chiefly to give the mother the pleasure of seeing the baby. During the next 24 hours it is taken to the breast every 6 hours. Babies weighing 7 lbs. and over are then put on the 4 hours schedule (both breasts at each nursing), omitting the 2 a.m. feeding. The baby readily adapts itself to this schedule, and spares the mother the chore of nursing at 2 a.m. after she leaves the hospital.

Babies weighing 5½ to 7 lbs. are placed on a 3 hour schedule during the day and 4 hour at night, nursing on but one breast at each feeding.

Premature and immature infants (less than 5½ lbs.) are given incubator care, and are not given water, food or a bath the first 24 hours.

3. We believe a supplementary feeding until the breast milk is established is well indicated. It prevents inanition fever, reduces the so-called physiologic birth weight loss, and affords the mother considerable peace of mind.

Our favorite formula, a simple and practical one is the following:

Evaported milk IV
Karo syrup ss
Boiled water VIII

Sig: I — II P.C. until breast milk is established.

4. *Circumcision. Too many babies are needlessly circumcized,* and there are two common errors in the usual technic: the removal of too much foreskin, and unnecessary suturing.

Nature intended the glans be completely covered. Therefore, we should strive to have it at least two-thirds or three-fourths covered. The cornification of the epithelial covering of the exposed glans, which results from the glans rubbing against the trouser flap during the many years of growing manhood, sometimes hampers the pleasure of the marital act in later life.

Hemostasis is the only indication for sutures, and they are rarely found necessary. The clamp method greatly eliminates their need.

An excellent *circumcision dressing* is a rolled five or six inch piece of surgical gauze three-fourths of an inch wide, autoclaved in albolene. The dressing is applied by wrapping it firmly about the penis, and it is not disturbed until it drops off about the third or fourth day. At that time the wound is sufficiently healed as not to require further dressing. The two advantages of this dressing are it does not have to be changed, and it permits the infant to urinate through it rather than into it.

5. A much appreciated service, particularly by the mother and grandmother, is the *removal of the cord stump* before the baby is taken from the hospital. This can be safely done as early as the fifth postpartum day, and is readily performed by twisting the stump off either with a piece of gauze or with the aid of a hemostat. The oozing base is treated with a silver nitrate

stick, and then covered with a tincture of merthiolate dressing. This has been our routine the past several years, and we can strongly recommended the procedure.

POSTPARTUM CARE

The responsibility of adequate portpartum care does not end at the six weeks examination, but should be continued throughout the first year with check-ups at three months, six months, and one year.

At the six weeks examination, the mother should be checked as to involution and position of the uterus, perineal healing, blood pressure, urine, and hemoglobin.

Two-thirds of all retroversions that did not exist prior to pregnancy can be permanently corrected by use of the pessary.

The infant, which as a rule has been placed in the hands of the pediatrician or family physician and checked before leaving the hospital, is seen only at this visit, and is checked for the condition of the naval and circumcision.

Any endocervicitis found after the third month should be completely eradicated. This can be done in practically all cases by an office cautery. But few services are more appreciated by the patient, in that it not only eliminates a rather common forerunner of cancer, but the leukorrheal nuisance as well.

A woman does not have to have a leukorrheal discharge just because she has had a baby. Postpartum care is frequently synonymatic with preconceptional care.

"HUMAN RELATIONS"

No branch of medicine lends itself so closely to human relations as obstetrics. *The birth of a baby is the most humane event in all life.* It evokes the most joyous interest of every family member, and the worthy attendant will capitalize upon sharing the exaltation.

Let us be reminded, *the obstetrician should not wear the cheerless face of a mortician.* At all times his lot is to eminate cheerfulness, and in this light, he should always be tactful enough to have a patient smiling as she leaves his office. The word, "easy", should be frequently employed when discussing her case with her. It is well to interject occassionally such remarks as, "Mrs. 'Jones', your measurements are normal. I am sure you are going to have an easy delivery." Or, "Your baby lies in an easy position, and you should have no difficulty". Or again, "Tell Mr. 'Jones', your blood pressure and urine have continued normal, and that your progress has been excellent." Yes, simple statements, but how they do register!

Above all, let us not overlook the husband's interest in the case. *When a husband asks us to deliver his wife, he is paying us a special compliment.* This is true whether or not the remuneration will be immediately forthcoming.

Certainly we should have more than a casual speaking acquaintance with him. He should be invited to make at least one visit to the office during the prenatal period. At this visit we should meet him as man to man, and let him know we expect to give his wife the best possible care, and that we would appreciate his co-operation by getting in touch with us anytime he has any question about her welfare, or if there are any abnormal symptoms he would like to report, et cetra.

Probably our biggest service to him is keeping him informed as to his wife's progress during her labor. *Here the Golden Rule is very fitting.* It is certainly inconsiderate of us, when we allow him to "sweat it out" hour after hour in the waiting room. If the labor should be prolonged, it is a kindly thing to advise him to go home for some sleep, or to return to his office, and assure him we will report to him from time to time, or at least when his wife is to be taken to the delivery room. And when we report the outcome of the delivery to him, let us be prepared not only to give his wife's condition and the sex of the baby, but also its weight.

These remarks upon "Human Relations" can be interpreted and appraised as those of "Good Public Relations."

In conclusion, the over-all emphasis of this presentation has been upon the importance of service to the patient. Let it be said, "If we give service, only two things can prevent our success, physical death and moral death. The one is inevitable, the other is up to us."

Finally, I would like to leave the souvenir thought, —

The Mortal life of a worthy obstetrician extends far beyond his tomb.

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An Evaluation of Five Years Experience With Continuous Caudal Anesthesia

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Since the publication and work by Hingson and Edwards[2] in the application of continous caudal anesthesia to obstetrics, there has been initial high degree of interest and productivity of statistics, pro and con. Most of these works were carried on in fairly large institutions, where complete house staffs and resident anesthetists were the rule. From their figures certain trends of ideas developed among which was the opinion that caudal anesthesia should be restrained and practically limited to institutions with house staffs. While content to gather information as to the technical aspects of continuous caudal and statistical results, it was felt that the only place to determine the applicability of continuous caudal in smaller hospitals was in such a hospital itself. With this in mind, our obstetrical cases have been reviewed from the time we started using caudals in May 1943 through April 1, 1948. There were a total of 2044 deliveries. An attempt will be made to evaluate obstetrical results using statistics only where necessary, so that the subject of this paper will not be a boresome repetition of uninteresting figures. The impressions obtained are the results gathered from complete personal contact with the patient throughout the application of the technique.

The obstetrical procedures were carried out between two hospitals in the Champaign-Urbana area. One of these, Mercy hospital, is a general hospital with a rated capacity of 90 beds, and an obstetrical floor normally designed to accommodate 220B patients. The other hospital, Burnham City Hospital, has a normal capacity of 110, with provisions for approximately 18 OB patients.

Neither hospital has a house physician, but both have a well organized medical staff, and each has an active obstetrical committee.

This report includes a total of 2044 deliveries, 1126 with a caudal, an incidence of 55%. Infant mortality includes all deaths; still births included, of infants having attained 28 weeks of introuterine gestation.

In this review, the period May 1943 to May 1944 was the first year of exeperience with continuous caudal. During this year there were a total of 420 deliveries of which 222 or 52.9% were delivered by caudal. This 52.9% constitutes caudals which the patient and the operator considered satisfactory from an analgesic and anesthetic standpoint. A higher percentage was attempted but it was found that in approximately 10%, it was not possible to insert the needle-or when it was thought that the needle was properly placed, results were ineffective. Of this total group, 326 were primiparas and 94 multipara. In this group there were a total of 9 caesarian sections, or a 2.1% incidence of sections, of which 4 were performed under caudal anesthesia. There was no maternal mortality in this group, and one serious complication following the use of caudal.

Our infant mortality was 11, a 2.5% incidence. Of these, 7 were in the caudal group and 4 in the group in which a general or no anesthesia had been employed. The one troublesome complication occurred in a very obese individual in whom a caudal should never have been attempted. This patient developed an abscess deep in the perisacal tissue which required incision and drainage. In reflecting upon this first year of caudal experience, we found ourselves very enthusiastic about the entire procedure, despite the fact that anywhere from 2-16 hours were spent with individual patients in labor. The calmness that prevailed in the labor room plus the apparent cheerfulness of most mothers, plus the ease of delivery—and the very definite decrease of blood loss following the third stage, kept enthusiasm at a high level. Since the patient was not under a general anesthetic, the episiotomy wounds could be repaired leisurely without worrying

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about an anesthetic causing hemorrhage incident to uterine relaxation.

Being accustomed to an almost routine outlet forceps and episiotomy for primigravida under any form of anesthesia, operative incidence was not appreciably increased. However, there was certainly a definite increase in occiput posteriors and deep transverse arrests, but it was felt that corrective manipulations were extremely easy in most instances because of the greater degree of relaxation of the pelvic floor. Caudal anesthesias were administered to as many cases as possible and whenever possible, except for the definite contra-indications which are given by Hingson[4] and are so generally well known. A small percentage of our cases showed an appreciable hypotension associated with marked pallor and anxiety, but found this not too troublesome because most of these cases responded promptly with simple elevation of both legs and passive bicycle type leg exercises. In others, Ephedrine Sulfate 1.M was administered and restored B.P. levels to near normal. In only 2 cases was it felt necessary to discontinue the anesthesia because of continuing hypotension and syncope in the patient. There were 2 cases that showed definite syncopal symptoms after the test dose of 8 cc. with muscle tremors and some jactitation which were only momentary, but nevertheless frightening for a short period of time. In none of these cases was there any significant fetal distress either intrauterine or after delivery of the infant. It goes without saying that the first 25 cases gave the highest percentage of inability to insert the needle properly, but proficiency increased rapidly. Greatest success was attained after the malleable needle was discarded and replaced entirely with the rubber catheter method described by Manalou[1]. Before long the quantity of the test dose was diminished, and instead of injecting 8cc. only 4cc. was injected. It was felt that this would give us information regarding intravascular injection or unusual sensitivity to the drug. After 5 minutes the remaining 4cc. was administered and then another 5 minutes was allowed for signs of spinal anesthesia, before going ahead with the additional 20-25cc. of Metycaine necessary to produce an effective level. There were 4 cases of a low lying dural sac and test aspiration revealed spinal fluid, and therefore no further attempt to use caudal was made. These 4 cases occurred in the entire series. Most patients took to the idea of caudal favorably, but there was also a considerable percentage who feared the idea of a "needle in the spine". After about six months we began to hear reports about terrible cases of paralysis, backache, headaches, and even cases of fatalities which strangely "escaped our attention" while the patients were still under care in the hospital. These reports seldom came from the patients themselves, but from someone else. There were a few cases who were sure that their backaches and post-partum depression and lassitude was attributable only to the caudal. These complaints were evaluated carefully and it was felt that there was no increase in these sequelae following caudal, than would follow the ordinary process of parturition. There were patients who delivered during this time who had not been given caudal but were under the impression that they had been given caudals, and they too developed many symptoms supposedly due to caudal. In other words, we could find no real complications following caudals in any of the cases.

Thus we concluded our first year of experience, and we felt elated with our results. From May 1944 to May 1945 there were a total of 427 patients of which 221 received caudal or a 64.2% incidence. In this group 130 were multipara and 297 primipara. There were a total of 10 sections, or an incidence of 2.3%. Of these 10 cases 6 were performed with caudal and 4 under general anesthesia. There was no material mortality and no serious sequellae resulting from caudal. The infant mortality for the entire group was 9, and incidence of 2.1% with 2 for those under caudal. The catheter technique described by Adams and Lundy[3] was used completely, because it was felt that the proper insertion of the catheter was easier than the malleable needle, and also that there was less apprehension about manipulating a patient than with a needle in situ. Although the percentage of caudal had increased over the previous year, there was a more carefull selection of cases in advance of labor as to their suitability for the procedure. That is, people who seemed to be emotionally unstable or had complaints such as chronic headaches or backaches, were eliminated. By the elimination of these individuals, better evaluation of sequellae resulting from

the procedure was possible. Individuals who spontaneously expressed a fear of the method were eliminated, nor were patients influenced in accepting the procedure. The method was used in all types of presentation, including breeches. After selection of proper cases and once the patient went into labor, the administration of caudal was started only when the patient became definitely uncomfortable and asked for relief, and then the caudal was given only when there was active progress of labor. The degree of cervical dilatation was not used as a rigid formula, but in addition to the subjective symptoms. In doing this it was found that in contrast to the previous year, the duration of caudal administration was considerably decreased and there were practically no cases in which the caudal was administered longer than an 8 hour period. This had two distinct advantages. The most important one was the patient's reaction. Whereas previously caudals were administered quite soon after the onset of labor and before the patient was in real distress, some patients felt that they had not performed their duty as a mother. Another patient reaction with a long continuous caudal was a rather constant restlessness and apprehension which inevitably made its appearance. Many patients did not like the feeling of complete helplessness and also developed anxiety about what was happening and wondered if they were really making progress. A great deal of encouragement was necessary to convince the patient that their child would eventually be born. The effectiveness of caudal very definitely decreased after about 8 hours, and more frequent refills were necessary and analgesia was no longer complete. The other advantage with a shorter caudal was our own personal reaction. Despite our elation with the method, weariness began to dull enthusiasm, and we found ourselves losing our cheery disposition a little more readily. At times there was an inclination to speed up the second stage and unless great personal discipline was used, a few of the low forcep deliveries were becoming a little less low. Fortunately, obstetrical conscience prevailed before there were any serious accidents. Our reactions then at the end of this second year of effort were something like this: Many more women than we realized would go along well into the first stage of labor with minimal sedation when they were given assurance that complete relief would be forthcoming whenever they required it, provided that sufficient progress was evident. Many more women had a glow of satisfaction at their own efforts and then were lavish in their praise of a method that gave them such dramatic relief when they desired it.

From May 1945 to May 1946, we had a total of 334 deliveries, of which a total of 214 were performed under caudal or an incidence of 71%. There were 121 multipara, 213 primipara and no maternal mortality. Fetal mortality for the entire group was 6, and incidence of 1.8% of which 4 occurred in caudals. There were 13 sections, a 3.6% incidence, 5 of which were performed under caudal anesthesia. Initially we were quite thrilled with our results of caesarian with caudal. With effective levels obtained by consecutive 10cc. injections at intervals we were able to bring the level of anesthesia above the umbilicus, and the patient experienced no pain during the procedure. The operator would proceed leisurely and no infants required resuscitation. The very definite decrease of uterine hemorrhage was an extreme advantage. The lack of anesthetic effects on the infant too, was striking. The disadvantages of continuous caudal in ceasarian were two-fold. The first was the time consuming factor in obtaining proper anesthetic levels, and sometimes 45 minutes elapsed before proper levels were obtained to proceed with surgery. There were also several cases in which there was a precipitous drop in systolic pressure, and the patient showed marked pallor and restlessness, although the pulse volume remained good. Despite no apparent ill effects to mother or infant, it was a real concern to us to proceed with a surgical procedure with a patient in marked hypotension.

From May 1946 to May 1947 there were a total of 438 deliveries of which 251 or 57.3% were delivered with caudal. There were 190 multipara and 248 primipara. There was no maternal mortality and there was an infant mortality of 3 in the caudal group and 3 in the general group, a total incidence of 1.3%. There were 23 sections performed for a 5% incidence and caudal was used in only 2 of these. From May 1947 to May 1948 there were 425 deliveries of which 218, or 51%, were delivered with caudal. There was no maternal mortality. There were 4 infant deaths in the caudal group and 4

in the control group for a 1.8% total. Twelve caesarians were performed for a 2.7% incidence and no caudals employed. During these last two years, then, it was apparent that we almost completely discarded caudal in caesarians for the reasons mentioned previously.

It will be noted that approximately 55% of caudal deliveries was attained and that this percentage was the result of trying to use caudal whenever possible. We wanted to see in what percentage of cases caudal could be employed, because a method must be practicable if it is to be at all worthwhile. There were considerable cases in that group who received caudal who could undoubtedly been carried along with other methods without undue hardship on the mother.

The usual post-partum complication, such as inability to void was not appreciably increased over other methods. The most frequent complaint was intense backache lasting from one half hour to four hours, whenever the caudal effects were dissipated. Headaches were very infrequent and post-anesthesia muscle paralysis, or a loss of sphincter control did not occur in any of the cases. Most of the cases were out of bed on the second post-partum day. In summary then, a total of 2044 obstetrical cases were reviewed in which caudal was employed in 1126 with an incidence of 51%. Continuous caudal anesthesia was an effective method of controlling labor pains and affording maximum relief during delivery period. Each individual administration must be given with careful observation of all rules, and no shortcuts must be permitted. There must be a careful evaluation of the patient from both a psychological and emotional standpoint, as well as an obstetrical standpoint. Any untoward effects of the anesthetic in the early minutes of the administration should preclude further administration despite demands of the patient. The administration of caudal should not be pushed and used only when the individual case warrants it. One of the chief advantages of caudal is from the operators' standpoint and great restraint must be employed less the advantage cloud his obstetrical judgment.

Continuous caudal anesthesia can be administered in smaller hospitals in selected cases, provided the operator is willing to spend considerable time in learning the technique, rigidly observing all precautions and willing to spend additional hours with the patient in labor.

It must be emphasized and re-emphasized that continuous caudal is not an average procedure and it is not necessarily needed in the average case. When and where indicated, continuous caudal is a valuable adjunct in long difficult labors, in which case it provides much needed rest without inhabiting labor, and not unimportant in the relief of pressure a worried husband or mother applies to the obstetrician to terminate a case before termination is proper.

In small hospitals caudal anesthesia is advantageous where operative procedures are contemplated rather depending upon inexperienced nurse personnel to administer ether in a haphazard manner.

From the results obtained continuous caudal anesthesia is a safe procedure when properly administered, and while it will probably never obtain status of general use, it is a very valuable adjunct to obstetrical anesthesia armamentarium.

I wish to acknowledge the aid of Velma Herington, R.N. in compiling these statistics.

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Radioactive Digitoxin

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of the
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Dr. Kelsey: The Department of Pharmacology at the University of Chicago under the direction of Dr. Eugene M. K. Geiling has long been interested in cardiotonic drugs. Since radioactive carbon became available, during the past five years, we have enlarged our pharmacologic investigation of digitoxin through tracer studies. These studies have required considerable joint effort, and credit for much of what I am presenting to you today must be given to four or five staff members and ten to fifteen graduate students who worked with us during this period. The use of a radioactive tracer technique has added an important tool to our investigative attempts since chemical and biological methods to assay digitoxin and its metabolites are neither specific nor sufficiently sensitive.

Our supply of radioactive digitoxin is produced by biosynthesis in our laboratory. The plant, Digitalis purpurea, is grown in a sealed battery jar into which is introduced carbon dioxide with the carbon being the radioactive isotope C_{14}. The outside leaves of this plant may be removed from time to time without injury to its proliferative properties. The plant will thus continue to supply radioactive leaves over a period of a year or more. Through an elaborate chemical extraction process digitoxin is removed from the dried leaf, giving about a 0.1% yield. This material has a radioactivity of approximately 500,000 counts per minute per milligram, or approximately one microcurie per 1.5 mg dose.

We were first interested in determining the fate of injected digitoxin in experimental animals. Guinea pigs and cats were given doses far in excess of digitalizing doses for humans on a relative weight basis and were sacrificed after two hours. Various organs and excretions were isolated and chemical extractions were performed to separate unchanged digitoxin from other substances having radioactivity, namely, the metabolites of digitoxin. Under these circumstances there appeared to be a practically uniform distribution of unchanged digitoxin in all organs; thus the heart did not have any higher concentration of digitoxin than did skeletal muscle. This is in marked contrast to reported studies using bio-assay methods in which digitalis-like activity was ten times greater in heart muscle than in skeletal muscle following the administration of these glycosides. Some digitoxin was found in all of the excretions, but in all instances there was a much greater excretion of metabolites than of unchanged digitoxin. Large quantities were found in the urine, gastric contents and intestinal contents, even though the drug was given intravenously. In the bile fistula dog, 84% of the radioactive material was recovered from the bile, urine and feces within 48 hours, 2/3rds of the radioactive carbon in the form of metabolites of digitoxin. After giving an intravenous dose to dogs, only 38% of the radioactiviy remains in the blood at the end of 5 minutes, 14% at the end of 10 minutes, and 1% at the end of 15 minutes.

Inasmuch as our primary interest is in the metabolism of digitoxin in humans, we were permitted by The Atomic Energy Commission to study the radioactive drug in several cardiac patients. These were prolonged and tedious experiments, requiring not only close clinical observation but also laborious extractions of the excreta. Whereas in the dog, only 1% of the injected drug remained in the blood stream at 15 minutes, in the humans 10% yet remained at the end of 30 minutes. Unchanged digitoxin was excreted in the urine in the patient most

closely studied to the extent of 1.6% of the total dose during the first 24 hours, 0.8% during the second 24 hours, 0.4% during the 3rd 24 hours, with a total of 7% during the first month. An elaborate system of extractions was used on each urine specimen, and the radioactivity of each fraction determined. Some of the radioactive metabolites were found in the fraction known to include digitoxigenin but only for the first 12 days. Several different fractions, indicating at least that many discreet metabolites, showed significant radioactivity. Greatest activity was shown in a water-soluble fraction. The chemical nature of the metabolite or metabolites contained in this fraction is unknown. Bioassay of this fraction for digitalis-like activity has not yet been done in our laboratory. The absence of radioactivity in certain of the fractions rules out the possibility that the first step in metabolism is the splitting off of a simple carbohydrate from the glycoside molecule.

Work of this type is still in its infancy but certain implications are evident from the data now available and some speculation is warranted. We do not know whether digitalis per se is cardiotonic or whether only its metabolites are active. From a comparison of bioassay and radioisotope assay of concentrations in heart and skeletal muscle after a dose of digitoxin, it would appear that all of the pharmacologically active substance is not digitoxin. Likewise the prolonged pharmacologic effect of digitoxin does not correlate with the rate of excretion of the parent drug and its metabolites. The activity might represent the retention of a small metabolic fragment or of an induced biochemical change which persists.

If the true activity is due to a metabolite of digitoxin, a logical explanation is offered for the great individual variability in response to this drug among patients. Thus a relative insensitivity to the glycoside might be due to a deficiency of an enzyme responsible for the intermediary metabolism of digitoxin, such deficiency being entirely unrelated to the heart but possibly to some other organ such as the liver.

In summary, digitoxin per se is rapidly metabolized and excreted. The nature and action of its metabolites are yet to be determined, but it seems likely that the action of digitalis is largely due to one or more of these metabolites. We are continuing to explore the subject and its many ramifications by means of radioactive tracers combined with chemical and bioassay techniques.

Dr. Robert W. Keeton, Professor of Medicine, University of Illinois: It has been noted clinically that marked diuresis in an edamatous patient poteniates the digitalis effect. Have your studies thrown any light on this problem?

Dr. Kelsey: Some of our patients have had edema prior to their dose of radioactive digitoxin. It appears that an increased urinary output does increase the excretion of digitoxin and its metabolites. The potentiating effect of diuresis might possibly be due to a stepping up of the potassium excretion noted early after the injection of digitoxin. We have not particularly investigated this aspect of the problem, however.

Dr. Louis A. Selverstone, Instructor in Medicine, University of Illinois: Clinically we feel that 100% of an oral dose of digitoxin is rapidly absorbed. Have you checked this in any of your studies?

Dr. Kelsey: No. We have given all of our doses intravenously. It would be a difficult matter to check inasmuch as the drug is so rapidly excreted from the blood into the gastrointestinal tract.

Dr. Robert L. Grissom, Assistant Professor of Medicine, University of Illinois: Have you applied this technique to the study of any other drugs?

Dr. Kelsey: We have not attempted the study of other cardiotonic glycosides, but we are applying this method of radioactive biosynthesis to certain alkaloids. We have been able to produce radioactive nicotine, morphine, atropine and veratrine. We are at present constructing a much larger growth chamber in which we can better control the light and humidity. We have been able to produce radioactive tropical toads by feeding them radioactive snails which have eaten radioactive lettuce grown by this technique. A radioactive cardiotonic agent can then be obtained from the toad.

Galactose Tolerance Test

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The purpose of this study was to evaluate the importance and practicability of this laboratory test. The series of cases studied over a four-year period included: 35 thyrotoxic goiters, 50 cases of chronic cholecystitis and cholelithiasis, 12 cases of carcinoma of breast, 10 cases goiter carcinoma, 8 cases carcinoma of caecum and ascending colon, 6 cases carcinoma of descending colon and sigmoid, 3 cases of regional ileitis, 6 cases of extreme emotional instability (menopausal in nature). Additional non-surgical cases were also included in this group. No attempts were made to classify as to age or sex.

Interpretation Of The Galactose Tolerance Test:— Physiology.

The test known as the galactose tolerance test is not too commonly used and its importance is frequently overlooked. Harting and Grant[1] in 1933 indicated that galactose had a very low renal threshold. Lichtman[2] in 1931, and again in 1932 showed that cases of thyrotoxicosis exhibited a diminished tolerance for galactose. Althausen and Wever's[3] experimental work agreed with the above findings, but the exact physiology involved was in question. Bollman, Mann and Power[4] demonstrated that the liver metabolized galactose, and that other tissues of the body enter into the process of metabolizing galactose slightly, if at all.

Althausen, Lockhart and Soley[5] devised an oral galactose tolerance curve, and MacLagan and Rundle[6] worked independently in 1940 using this tolerance curve, as an aid in the diagnosis of hyperthyroidism. Their interpretations and opinions regarding the physiology of the galactose tolerance tests seem to differ. A number of the investigators are of the opinion that the decreased tolerance of galactose is the result of specific liver damage; and that this specific liver damage (cellular) in turn interferes with the conversion of galactose to glycogen. Others hold that the decreased galactose tolerance is possibly due to increased galactose absorption from the gastro-intestinal tract. It is generaly accepted that liver function is impaired in hyperthyroidism. Bartells[7] in 1938 demonstrated the effect of hyperthyroidism on the glycogenic function of the liver, as evidenced by the Hippuric acid excretion tests. He indicated graphically the relationship of the function (depression of glycogenic function) associated with the increased metabolic rate. He also noted that recovery of this function (as evidenced by Hippuric acid excretion) was very closely related to the return to normal of the metabolic rate. We are aware that liver function is impaired in some cases of hyperthyroidism, and that if hyperthyroidism persists, actual liver damage may result. This damage if severe may account for the death of the patient involved.

Experimental work by Russell[8] in 1938 indicated that thyroxin (in rats) administered experimentally, greatly increased the absorption of galactose from the alimentary tract.

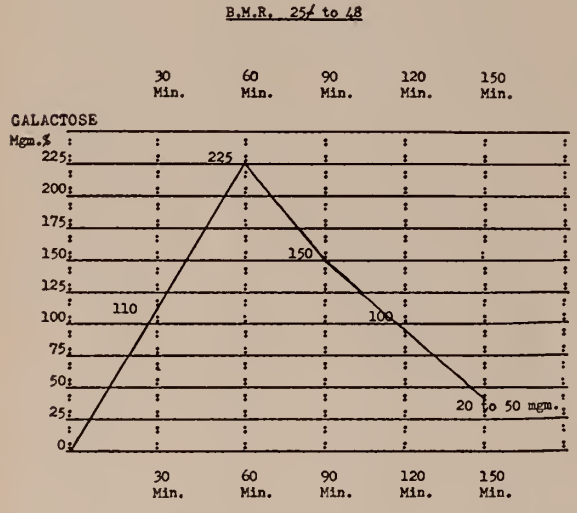
It is well known clinically that the administration of thyroid material to patients suffering with sprue aids in the absorption of galactose from the alimentary tract. It is important to determine whether the liver, or the intestine itself is responsible for the abnormal galactose tolerance curve in hyperthyroidism.

King and Atkin[9] in 1940 administered galactose intravenously, thereby eliminating the gastro-intestinal tract; thus this method constituted a liver function test. These investigators concluded by their experiments that intravenous galactose values are seldom altered except in cases exhibiting acute or extensive liver damage.

Barnes and King[10] in 1943 presented an excellent paper covering the testing of 40 patients suffering with hyperthyroidism by both the intravenous and oral methods. They were convinced following their work, that the findings of an abnormal galactose tolerance curve and index (oral), in the presence of a normal intravenous galactose tolerance level was the result of abnormally rapid absorption of the galactose from the intestine.

The authors found in a series of cases (35) suffering from thyrotoxicosis associated with hyperthyroidism that the galactose tolerance curve was elevated. The term "galactose index"

was coined by Barnes and King[10]. The galactose index is simply the total readings as graphically presented by the galactose tolerance curve at thirty (30) minutes, sixty (60) minutes, ninety (90) minutes, and one-hundred and twenty (120) minutes. The chart below is a mean average galactose. It represents the average readings obtained on thirty-five (35) cases of thyrotoxicosis with hypermetabolism possessing basal metabolic readings from 25 to 48. It was found that in 8% of the cases the galactose could be measured in the blood in concentrates of 20-50 mgm. at a one-hundred and fifty (150) minute lapse. In general, those cases having glands enlarged 2 to 3 times normal size showed a "higher" galactose index. The degree of elevation of the galactose index did not always parallel the degree of elevation displayed by the basal metabolic rate.



It was observed that those cases which had been previously medicated and gave a relatively low B.M.R. reading were in some instances responsible for high galactose index readings. The galactose index rise apparently paralleled the increase in the B.M.R. readings in those cases that had not been previously medicated. It was not uncommon to find a supposedly controlled case (medically) rendering a normal basal metabolic rate and at the same time showing an elevated galactose index. For this reason it was thought that the galactose index would prove to be useful not only in the diagnosis of thyrotoxicosis; but also in obtaining an estimate of glandular (thyroid) activity. This would be especially true in those cases which had been treated over long periods of time with various drugs. Barnes and King[10] used a galactose index reading of one-hundred and twenty (120) units as the upper limits of normal. They reviewed the one-hundred and twenty (120) cases that they regarded as normal control cases. These cases were human — non-thyrotoxic cases, and they exhibited no findings that could be construed as being associated with hyperthyroidism. Thus they arrived at the figure of one-hundred and twenty (120) units as being the upper limits of normal. They were also of the opinion that because of the wide range of normal — it would be difficult to diagnose early thyroid disease. This is also the same objection that can be raised regarding the basal metabolic rate (test). The diagnosis of early hyperthyroidism is obviously one of the clinicians greatest problems. The galactose tolerance curve — particularly its elongation following one-hundred and twenty (120) minute intervals, and the galactose index have been valuable in detecting some moderate and early cases of hyperthyroidism. It was hoped that the initial portion of the galactose tolerance curve would be abnormally effected to such a degree that it would become diagnostic of hyperthyroidism. This unfortunately is not true. The galactose tolerance curve and the galactose index determination are not always capable of rendering a diagnosis in all cases of thyrotoxicosis that are of a slight degree. Possibly comparative studies of the galactose tolerance curve and index repeated on doubtful or suspected cases, that are either an early or moderate in degree would reveal changes in the galactose tolerance curve and index values. If changes did occur, it could possibly be interpreted as some progressive change occurring within the thyroid gland.

The authors have not found the galactose tolerance curve to be abnormally effected or the galactose index to be elevated above one-hundred and twenty (120) mgm. in cases of known liver disease.

In three (3) cases of suspected liver damage, two (2) laboratory tests were used: 1. The bromsulphalein, 2. The galactose tolerance test (both intravenous and oral). Results: A. The bromsulphalein test indicated liver damage in all three cases. B. The oral galactose tolerance test and galactose index did not indicate liver damage (not elevated). C. The intravenous

galactose tolerance curve and index was slightly elevated in cases two (II) and three (III). D. At surgery — the three (3) cases proved to have liver damage. Cases one (I) and two (II) were found to have chronic cholecystitis and cholelithiasis associated with hepatitis. Hepatitis was not severe in case one (I). The third (III) case proved to be a carcinoma primary of the liver.

Study indicates that the intravenous galactose tolerance curve and galactose index is a liver function test, but its true value as a liver function test cannot be estimated as being very practical in as much as its sensitivity is apparently not very high. It would be logical to assume that in view of the findings that the galactose tolerance curve and index, (both oral and intravenous) is not a sensitive liver test — when an oral abnormal galactose tolerance curve occurs, it is probably the result of a pathological process outside of the liver itself.

Althausen, Lockhart and Soley, Maclagan, Rundell and others, interested in this field, have used this test on patients suffering from pathological conditions other than thyroid diseases. They concluded that Paget's disease, hepatic diseases and infections, acute and chronic, can alter the galactose index. It has since been demonstrated that diabetes and renal diseases do not effect the galactose tolerance curve and index (oral). Experimental work has shown that the renal threshold of galactose is not effected in hyperthyroidism. The authors have not observed any abnormalities occurring in the galactose index in cases of chronic cholecystitis without clincal evidence of hepatitis. Three (3) cases of regional ileitis, ten (10 cases of gastric carcinoma, and eight (8) cases of carcinoma of the caecum and eight (8) cases of carcinoma of the large bowel did not effect the galactose tolerance curve or index. In six (6) cases that represented extreme emotional activity (menopausal) no abnormal changes in the galactose tolerance curve and index was noted. In view of the findings to date, the probability of the small bowel as being the site of absorption of galactose, and the thyroid gland as the regulating mechanism is probably the most logical explanation. The exact physiology involved is still questionable. The theory that the metabolism of phosphates and calcium is intricately involved with the process of carbohydrate absorption is not yet too generally accepted.

CONCLUSION

1. The galactose tolerance and index are elevated in thyrotoxicosis.
2. The galactose tolerance and index do not always parallel the B.M.R.
3. The galactose tolerance and index are a definite aid in evaluating the toxicity of the gland.
4. While the galactose tolerance and index are important in establishing a diagnosis in thyroid disease — it is not always diagnostic in early or moderate cases.
5. While advanced liver pathology may alter the findings of the galactose tolerance test — it is not primarily a liver function test.
6. The thyroid gland is probably the controlling mechanism with the small bowel acting as the absorbing site.

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CASE REPORTS



Bleeding from Unsupervised Use of Dicumarol

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Experience with Dicumarol has demonstrated that when properly administered, it can prevent or favorably influence the course of thromboembolic disease and myocardial infarction. Dicumarol affects the blood by depressing the values of prothrombin. The mechanism whereby this drug reduces the prothrombin is not fully understood; but it may be by depressing the synthesis of prothrombin in the liver through an effect on any enzymatic process.

Dicumarol or similar anticoagulants carry the danger of bleeding, particularly when laboratory facilities for estimating prothrombin activity are not frequently employed.

The following case illustrates the nature and danger of unsupervised Dicumarol medication.

D.R., a 71 year old white female was admitted to St. Mary's Hospital, Centralia on August 17, 1950 with a history of malaise, generalized aching, weakness, sore throat, fever and painful cervical adenopathy. The past history was noncontributory except that she had a laparotomy in 1935 for intestinal obstruction. Except for a 65 year old brother with an arrested pulmonary tuberculosis, the family history was irrelevant. Physical examination at the time of admission revealed a blood pressure of 160/82; oral temperature 101.4; respirations 20; pulse 110 per minute. The patient was a well-developed and well-nourished person who did not appear acutely ill.

Physical examination revealed a diffusely infected throat, enlarged tender cervical lymph nodes, harsh breath sounds over the right and left upper lobes anteriorly, an apical grade 3 systolic murmur, a right rectus incision scar and a grade 1 rectocele and cystocele.

Laboratory studies showed hemoglobin 82%, erythrocytes 4,400,000, leukocytes 8,200 with a differential count consisting of segmented neutrophils 91% and lymphocytes 9%. The nonprotein nitrogen was 27 mg. per 100 cc. of blood and glucose 136 mgm. per 100 cc. of blood. Urinalysis was negative. The electrocardiogram revealed a left axis deviation with some myocardial damage. Roentgenogram of the chest was essentially negative. At this time there was

no evidence of petechiae or ecchymosis either in the skin or mucous membranes.

Twenty-four hours after her admission into the hospital she developed an erythematous area with numerous small vesicles upon her forehead and left periorbital region and which spread by direct extension. Eight hours later it had extended to involve the butterfly area of the face and a diagnosis of erysipelas was made. She was subsequently isolated and given supportive therapy including sulfonamide drugs and penicillin. Her recovery was uneventful until the fifth hospital day when she complained of severe soreness in the both gluteal regions and over the lateral aspects of both orbital areas. The following day she developed diffuse ecchymotic areas in both buttocks and a massive hematoma over the left orbital region surrounded by numerous pin point subcutaneos hemorrhages. The consulting opthalmologist confirmed the findings and found no evidence of retinal hemorrhage, though the patient was unable to see out of the left eye. It was then discovered that the consulting ophthalmologist had seen this patient eighteen months earlier at which time he made the diagnosis of thrombosis of a branch of the left retinal vein. He had recommended to the referring physician that the patient be given a closely supervised course of Dicumarol therapy. He again saw the patient four months later and found no evidence of thrombosis or hemorrhage of the retina.

A prothrombin determination and coagulation time were obtained on the following day which showed a prothrombin content of 24 percent and a coagulation time of 10½ minutes. She then developed massive hematomas over the right eye, both sides of the face, both arms and over the entire left breast. She was then given 500 cc. of whole blood and an equal amount of normal saline. The next day the prothrombin level rose to 74 percent content. The coagulation time was 4 minutes and 50 seconds and the platelet count 175,000. Following the administration of another 300 cc. of whole blood, the prothrombin content was 100 percent and the platelet rose to 420,000.

Subsequent inquiry brought the fact that the patient has been taking 50 mgm. of Dicumarol daily for a period of over 18 months. During that time she did not report back to her physician for clinical observations and laboratory studies to determine any blood changes. She stated that when she ran out of medicine, she would obtain refills from a drug store without a prescription.

Her subsequent hospital course was uneventful, the ecchymotic areas gradually fading. The blood work-up two days prior to her discharge from the hospital showed a prothrombin value of 97 percent, coagulation time of 3½ minutes, hemoglobin 78 percent, erythrocytes 4,180,000 and platelet count 460,000.

SUMMARY AND CONCLUSIONS

(1) A case of severe bleeding following the use of Dicumarol in a patient who had been taking the drug for 18 months without returning to her physician for clinical observation and for determinations of the prothrombin time is presented.

(2) Dicumarol is a dangerous drug when taken without close medical supervision and frequent blood prothrombin determinations by a well trained technician.

(3) Patients should be told the nature and dangers of unsupervised Dicumarol therapy.

(4) Dicumarol should not be dispensed without a new prescription being written each time by the supervising physician.

NEWS OF THE STATE



COOK

Promotions at Illinois.—Promotion of seven members of the faculty of the University of Illinois College of Medicine to the rank of full professor has been announced by Dean Stanley W. Olson. The promotions are as follows:

Dr. Geza de Takats, from clinical associate professor of surgery to clinical professor. He has been a member of the UI faculty since 1934.

Dr. M. I. Grossman, from associate professor of clinical science to professor. Dr. Grossman, now a captain in the Army Medical Corps stationed in Chicago, joined the University of Illinois in 1946 as an assistant professor.

Dr. J. E. Kempf, from associate professor of bacteriology to professor. His initial UI appointment was in 1946 as an associate professor.

Dr. Adolph Rostenberg, Jr., from associate professor of dermatology to professor. He has been a member of the faculty since 1945 when he was appointed with the rank of associate professor.

Dr. Max S. Sadove, from associate professor of surgery to professor. Dr. Sadove, who heads the division of anesthesia, received his initial University of Illinois appointment in 1947 as an assistant professor.

Dr. Walter H. Theobald, from clinical associate professor of otolaryngology to clinical professor. Dr. Theobald has served the University of Illinois for 26 years.

Dr. Willard Van Hazel, from clinical associate professor of surgery to clinical professor. Dr. Van Hazel has been associated with the Research and Educational Hospitals continuously since his appointment as a resident in ophthalmology in 1925.

Personal.—Dr. Walter C. Alvarez, Chicago, has been named editor-in-chief of Modern Medicine.—Dr. Ulysses Grant Dailey, well known Chicago surgeon, left New York by plane on October 7, 1951 for Pakistan where he will give lectures and clinics in surgery at the three medical centers of that country (Karachi, Lahore, and Dacca). The assignment under an exchange agreement between the State Department of the United States and the Pakistani government begins October 15, 1951. Dr. Dailey plans to return to his practice February 1, 1952.

University News.—The Third Annual Phi Delta Epsilon Fraternity lectureship honoring Doctors Isaac A. Abt, Julius H. Hess and John J. Sheinin was held October 22-24. Dr. William Dameshek, hematologist, New England Center Hospital, Boston, presented the following lectures: "Spleen and Hypersplenism", "Idiopathic Thrombocytopenic Purpura" and "Principles of Hemolytic Anemia." The annual banquet of the lectureship was held October 23. Guest speaker was Dr. Austin Smith, editor of the Journal of the American Medical Association.—Dr. Leonida Santamaria, assistant professor of general pathology, University of Perugia, Italy, and winner of a Fulbright Exchange Fellowship award, has arrived at the Chicago Medical School for a year of research in the department of physiology, according to an announcement by President John J. Sheinin. Dr. Santamaria will work under the direction of Dr. Piero P. Foa, professor of physiology and pharmacology on the physiology of the pancreas, and collaborate with Dr. Foa and Dr. A. R. Goldfarb, associate in the department of biochemistry, on metabolic problems involving use

of radioactive isotopes.—Dr. Karl H. Martloff, associate clinical professor of surgery, University of Oregon Medical School, gave the Charles Sumner Bacon lecture at an assembly hour, October 10, at the University of Illinois College of Medicine, on "Cancer of the Cervex Uteri: Analysis of Factors Influencing the Use of Surgery in Its Treatment."

Dr. LeRoy Named Associate Dean.—Dr. George V. LeRoy, atomic specialist and alumnus of the University of Chicago School of Medicine, was appointed associate dean of the university's division of biological sciences and associate professor of medicine, Dr. Lowell T. Coggeshall, dean of the division, announced October 1. Dr. LeRoy, who supervised the biomedical program of the Eniwetok atomic-weapons test, will assume his new duties immediately. Dr. LeRoy, a 1934 honors graduate of Chicago's medical school, was director and organizer of the radioisotope unit at the Veterans Administration Hospital, Hines, Illinois, from 1947 to 1951. He was granted leave from Hines to conduct the Eniwetok medical program for the Atomic Energy Commission, and on his return was made a consultant to the Los Alamos Scientific Laboratory, the University of California. Following World War II, Dr. LeRoy was sent to Japan by the commission to study atomic-bomb casualties. A lieutenant-colonel in the U.S. medical corps, he served as chief of the medical service at station hospitals in New Caledonia, New Hebrides, Guadalcanal, the Marianas, and with the twelfth general hospital at Northwestern University. Dr. LeRoy, before the war, was on the staff of both Northwestern and Chicago universities. The Searle research fellow and instructor in medicine at Northwestern, Dr. LeRoy conducted research in cardiovascular physiology from 1938 until 1941. From 1935 to '38, he was an assistant in medicine at the University of Chicago Clinics, doing research in hematology. A cardiac consultant to the Municipal Social Hygiene Clinic from 1938 until his entrance into military service, Dr. LeRoy has also served as an associate attending physician on the staff of St. Luke's hospital. Forty-one-years-old, Dr. LeRoy was born in Wilkinsburg, Pennsylvania. He reecived his bachelor of science degree in 1932 from the University of Pittsburgh and attended the School of Medicine at West Virginia University before transferring to the University of Chicago. Dr. LeRoy is a member of the Central Society for Clinical Research, the Chicago Heart Association, the American Federation for Clinical Research, the American Medical Association, and Phi Chi.

Society News.—Dr. Sidney Smith addressed the Orange County Medical Society in Orlando, Fla., October 17, on "Coarctation of the Aorta." This was a clinical presentation illustrated with slides and a patient. On October 24, Dr. Smith addressed the Ottawa Woman's Club in Ottawa, Ill., on "Surgical Congenital Heart Disease".—Dr. T. J. Wachowski, clinical professor in radiology, University of Illinois College of Medicine, addressed the North Suburban Branch of the Chicago Medical Society, October 8, on "Medicine in the Atomic Age." On November 12, Dr. Emerson Ward, Rochester, Minnesota, discussed "Collagen Diseases."—The following speakers addressed the Chicago Tuberculosis Society at a meeting, October 29: Dr. Linden J. Wallner, Dr. J. Robert Thompson and Dr. M. R. Lichtenstein, on "Clinical and Histopathological Study of Cortisone and ACTH in Tuberculosis: Failure to Affect Mucosal Lesions"; Dr. J. Schlichter, "Sarcoidosis Complicating Rheumatic Fever"; and Dr. A. Keinigsberg, on "Pregnancy in Pulmonary Sarcoidosis: Report of Two Cases." Dr. Otto L. Bettag delivered the president's address, "Facts and Foolishness: Tuberculosis."—"The Clinical Manifestations and Management of Intestinal Obstruction" was the title of Dr. Manuel E. Lichtenstein's presentation before the Kenosha County Medical Society, October 4.

"Emotional Reactions to Stress."—The second annual North Shore Health Resort lectures series on "Emotional Reactions to Stress" opened October 3 with a talk by Dr. Lewis L. Robbins, director, department of adult psychiatry, Menninger Foundation, Topeka, Kansas, on "Failure and Frustration." Others in the series are Dr. Francis J. Gerty, professor and head of the department of psychiatry, University of Illinois College of Medicine, November 7, "Acute Illnesses"; Dr. V. G. Urse, associate professor of neuropsychiatry, Stritch School of Medicine of Loyola University, December 5, "Chronic Illnesses"; Dr. John Spiegel, associate director, Institute for Psychosomatic and Psychiatric Research and Training of Michael Reese Hospital, January 9, "Catastrophe"; Fritz Redl, Ph.D., professor of social work, Wayne University, Detroit, February 6, "Crime"; Dr. Jules H. Masserman, associate professor of nervous and mental diseases, Northwestern University Medical School, March 5, "Death and Suicide"; Dr. H. H. Garner, chairman, department of psychiatry, Chicago Medical School, April 2, "Divorce"; Dr. Boris B. Rubenstein, research associate, Institute for Psychosomatic and Psychiatric Research and Training of Michael Reese Hospital, May 7, "Fertility and Sterility"; and Dr. Leo H. Bartemeier, president, American Psychiatric Association, Detroit, June 8, "Marriage."

Dr. Bachmeyer Honored.—Dr. Arthur C. Bachmeyer, only recently associate dean of the University of Chicago's Division of Biological Sciences, was given a dinner by the university's science division, September 25, in honor of his becoming emeritus, October 1. Vice-president R. Wendell Harrison, Dr. Lowell T. Coggeshall, dean of the division of biological sciences, and Dr. Lester R. Dragstedt, chairman of the department of surgery, were guest speakers at the dinner. The only educator to hold all three presidencies, the American Association of Medical Colleges, (1951), the American College of Hospital Administrators (1940), and of the American Hospital Association (1926), Dr. Bachmeyer has served as a medical school dean for the past 26 years. He was appointed associate dean

of the university's medical and biological division in 1935 and had previously served as dean of the College of Medicine of the University of Cincinnati. At the University of Chicago, Dr. Bachmeyer has also served as director of the university's graduate program in hospital administration since 1935, and as a member of the student-selection committee of the medical school. During the past two years, Dr. Bachmeyer has been consultant to the university's ten-million dollar medical building program. He will remain a consultant on the construction of the $4,400,000 Gilman Smith and west wing hospitals and the $2,578,650 Argonne Cancer Research Hospital, now being built on the Midway campus by the Atomic Energy Commission. The 1950 recipient of the American Hospital Association award of merit, Dr. Bachmeyer served as director of the Commission on Hospital Care. From 1944 to 1946, the commission investigated hospital needs of the nation, out of which grew the Hill-Burton act to provide federal funds for construction of hospitals in critical areas.

Grants for Research.—The United States Public Health Service recently awarded five grants to the University of Illinois in support of investigations in the College of Medicine.

Two grants support research on the 25-million volt betatron. A grant in the amount of $23,191 has been renewed for another year for a study of the effects of the electron beam on bone and cartilage which is supervised by Dr. Roger A. Harvey and Dr. G. A. Bennett.

Effects of the electron beam on the central nervous system will continue to be studied by Dr. Harvey and Dr. Percival Bailey. A $15,816 grant again has been made available for this work.

A new grant in the amount of $14,206 has been awarded by the USPHS for an investigation of the antigenic and chemical qualities of rounded masses of tissues formed in the kidney. Dr. Cecil A. Krakower is directing this research.

Renewal of a $7,110 grant also has been made for an investigation of factors involved in the growth and dissolution of kidney stones. This study is being conducted under the supervision of Dr. C. W. Vermeulen.

Another new grant, in the amount of $4,158, has been awarded to Dr. Arthur Kirschbaum for a study of the tissue susceptibility of mice to stimuli which produce cancer, resulting in development of pulmonary ovarian, and adrenal tumors.

Special Lectures.—Dr. John H. Talbott, professor of medicine, University of Buffalo School of Medicine, presented the Fifth William Allen Pusey Memorial Lecture of the Institute of Medicine of Chicago, October 22. His subject was "Experimental Observations in Acute and Chronic Gout."—The fifteenth Christian Fenger Lecture of the Institute of Medicine of Chicago and the Chicago Pathological Society will be delivered at the Palmer House, Friday, November 23, at 8:00 o'clock by Dr. Anton J. Carlson, Frank P. Hixon distinguished service professor of physiology emeritus, the University of Chicago School of Medicine, on "Some Medicosocial Problems Created by Modern Medicine."—The thirty-sixth annual dinner and meeting of the Fellows of the Institute will be held at the Furniture Club of America, Tuesday, December 4. The presidential address will be delivered by Dr. Walter H. Theobald, clinical professor of otolaryngology, University of Illinois College of Medicine.

Dinner Honors Dr. Keeton.—Dr. Robert W. Keeton, distinguished for his academic contributions to Chicago medicine for more than 40 years, was honored October 4 at a dinner at the Furniture Club of America. The occasion was prompted by his retirement as professor and head of the department of internal medicine at the University of Illinois College of Medicine, a position which he has held since 1933. In that capacity, he directed the teaching and research activities of some 225 physicians who hold faculty appointments in the department. More than 400 colleagues, former students, and friends paid tribute to Dr. Keeton at the dinner. Speakers were Dr. Anton J. Carlson, professor of physiology, emeritus, University of Chicago School of Medicine, and the following from the University of Illinois College of Medicine: Dr. Andrew C. Ivy, vice president in charge of the Chicago Professional Colleges; Provost Coleman R. Griffith; Dr. Hugh McGuigan, professor of pharmacology, emeritus; Dr. Stanley W. Olson, dean of the College of Medicine; and Dr. Arthur C. Willard, president, emeritus. Master of ceremonies for the dinner was Dr. LeRoy H. Sloan, clinical professor of internal medicine, University of Illinois College of Medicine. Highlight of the evening was the presentation of a "Festschrift" to Dr. Keeton. The commemorative volume consisted of 36 original scientific papers written by his colleagues, former students and friends. The book was published by Charles C. Thomas, Springfield. Dr. Keeton, 68, has been associated with the University of Illinois College of Medicine continuously since 1925. Prior to that time, he taught at Albany Medical College, Northwestern University, James Millikin University and also at the University of Illinois. He is the author of more than 125 major publications. His interests have concerned particularly the fields of diabetes, nausea and vomiting, gastric physiology, nutrition, obesity, liver disease, the response of the individual to environmental changes, metabolism, and studies on convalescence under widely differing conditions. Dr. Keeton is a member of many medical and scientific societies, and has served as president of the Chicago Society of Internal Medicine and the Central Interurban Club. He has been active in the affairs of the National Board of Medical Examiners. A native of West Point, Miss., Dr. Keeton received the doctor of medicine degree from Northwestern University in 1916. He previously had received undergraduate degrees from Cumberland University and the University of Chicago, and the master of science degree from the University of Chicago.

Herman Kretschmer Wills One Million Dollars to Northwestern.—Northwestern University will receive approximately one million dollars from the estate of Dr. Herman L. Kretschmer, famous Chicago urologist, who died September 23. Dr. Kretschmer's will specified that the money should be used to establish the "Lucy and Edwin Kretschmer Fund of Northwestern University Medical School" for "special studies and investigations in the field of urology." The fund will be a memorial to his wife, Lucy Barnett, who died in 1942, and to his son Edwin, who died of cancer in 1941 at the age of 15. According to the terms of Dr. Kretschmer's will, Northwestern University is made the residuary beneficiary of his estate, the amount ultimately accruing to the University being conservatively estimated as in excess of $500,000, subject to an annuity to his son, Herman L. Kretschmer, Jr. In addition the University will receive about $275,000 from Dr. Kretschmer's life insurance, and the remainder after a life estate to Dr. Kretschmer's wife, Mrs. Marion Ellen Kretschmer in a trust fund now valued at about $180,000. The executor of the estate is the City National Bank and Trust Company of Chicago. Serving as attorney for the executor is Frederick Secord, of the law firm of Gann, Secord, Stead, and McIntosh. In commenting on the gift, President J. Roscoe Miller of Northwestern, said that Dr. Kretschmer was firmly opposed to socialized medicine, believing that one of the best ways to preserve private medical practice was to provide voluntary support for our medical schools, thus keeping them free from federal control. We have always been proud of Dr. Kretschmer's attainments, since he was a graduate of our medical school. We are now deeply grateful to him for his generosity. We shall do all in our power to carry out his commission to us, — that of aiding society by attacking the unsolved problems of urology." Dr. Kretschmer graduated from Northwestern's School of Pharmacy in 1900 and from the Medical School in 1904. He was awarded an honorary doctor of science degree by Northwestern in 1944, as "a loyal alumnus whose contributions to science, teaching, and organized medicine have brought great credit to his Alma Mater." He was president of the American Medical Association, 1943-45, and president of numerous other medical organizations, including the American Association of Genito-Urinary Surgeons, the American Urological Association, the Chicago Medical Society, the American Board of Urology, Inc., and the International Urology Association. He was the author of many important scientific papers, and had been a professor of urology at Rush Medical College and at the University of Illinois. Last year he was awarded the Keyes Memorial Medal by the American Association of Genito-Urinary Surgeons in recognition of his contributions in the field of urology.

Admission to Medical School.—Though the peak load of veterans is past, competition for admission to the University of Illinois College of Medicine remains as keen as it has been for all classes since the close of World War II. Examiner and Recorder George R. Moon has reported that almost all of the 166 students selected for enrollment in the first-year class in medicine this fall have scholastic averages of 88 percent (4.0) for three years or more of pre-medical college instruction. Minimum qualification for admission to the College, as established by the UI Board of Trustees, is 84 percent (3.5). Applications were received from 752 students this year, representing the largest total since 1948. Of that number, 560 met the minimum requirements of the College. The number accepted—166—is the same as in previous years. Ten students were admitted under the program which is sponsored jointly by the Illinois Agricultural Association and the Illinois State Medical Society. This program is designed to enroll more students from rural areas in medical schools, and to return them to their native areas to practice. The University of Illinois has agreed to accept a maximum of 10 students annually under the provisions of this agreement. The number of veterans of World War II who were accepted this year—20—represents a sharp drop from previous years. This compares with 67 in 1950, 97 in 1949, 61 in 1948, 123 in 1947, and 56 in 1946. Eleven women were accepted for the 1951 class. As in recent years, all new students are residents of Illinois. Half of those selected reside in Cook County, with the remainder from downstate areas, in direct ratio with the population of the state. Because of the great number of qualified applicants from Illinois, the Committee on Admissions deemed it inadvisible to accept non-resident students, even though 43 of them were rated as qualified. Factors in the selection of first-year students, in addition to scholarship, were the results of a professional aptitude test supervised by the Association of American Medical Colleges, recommendations from science teachers and pre-medical counselors, ratings on interviews with one or more members of the faculty, and a physical examination. Mr. Moon also announced that eight transfer students have been accepted for the third year of study. The transfer students were selected from more than 30 applicants.

Memorial Service for Dr. Hassin.—A memorial service for the late Dr. George B. Hassin, professor of neurology, emeritus, at the University of Illinois College of Medicine, was held September 23. Dr. Eric Oldberg presided at the memorial service which was held at the University. Speakers were two of Dr. Hassin's friends and associates, Dr. Leo Kaplan and Dr. Percival Bailey. Dr. Hassin, who died on August 15 at the age of 79, was regarded as the pioneer neuropathologist in the United States, and the foremost neuropathologist of his time. He founded the first special research laboratory in this country. He conducted investigations in his specialty for more than 35 years, during which time he gathered what is believed to be the largest collection—some 860—of valuable pathologic brains. He discarded an equal number because of lack of space. In addition, he prepared tens of thousands of micro-

scopic slides, illustrating almost every phase of neuropathology. Dr. Hassin was one of the most active producers of important contributions in the field of neurology and neuropathology. His bibliography comprised more than 180 original items. He was the author of three editions of the textbook, "Histopathology of the Peripheral and Central Nervous Systems," which long will remain a classic in its field. He edited the Journal of Neuropathology and Clinical Neurology.

He was one of the founders of the American Association of Neuropathologists, and was its first president in 1934. He was a member of all of the important clinical and research societies in neurology and neuropathology, and held honorary membership in the French Neurological Society and the American Academy of Neurology. He served as president of the Chicago Neurological Society in 1920, and was vice-president of the American Neurological Association in 1922. Dr. Hassin received his initial appointment to the University of Illinois College of Medicine in 1909.

Maurice Lev Goes to Florida.—Dr. Maurice Lev resigned from the University of Illinois College of Medicine, effective September 1, to accept a position as pathologist and chief of research laboratories at Mt. Sinai Hospital, Miami Beach. Dr. Lev held the rank of associate professor of pathology in the College of Medicine and associate pathologist of the Research and Educational Hospitals. He has been associated with the university during the past three years, during which time he was a recipient of the Raymond B. Allen Instructorship Award.

Dedicate Library in Honor of Dr. Hektoen.—The Hektoen Memorial Library was dedicated October 3 at Norwegian American Hospital. The library is named in honor of Dr. Ludwig Hektoen, world famous pathologist who died July 6. Dr. James P. Simonds, director of laboratories at Alexian Brothers Hospital and a former student and friend of Dr. Hektoen, was the principal speaker. An oil painting of Dr. Hektoen was presented by Lionell Thornsness, representing Mrs. Hektoen, and accepted by Birger Osland, honorary chairman of the hospital's trustees.

Lectures on Psychiatry.—On October 17, Dr. Rudolph Dreikurs, professor of psychiatry, Chicago Medical School, opened a series of lectures on psychiatry at the school. His discussion was "Holism in Medicine." Others in the series are Dr. Henry W. Brosin, chairman, department of psychiatry, University of Pittsburg School of Medicine, October 24, "Significant Advances in Psychiatry"; Dr. Gudmund Magnussen, chairman, department of neurology and psychiatry, Municipal Hospital, Copenhagen, Denmark, November 7, "Industrial Psychiatry"; Dr. Kenneth Soddy, assistant director, World Federation of Mental Health, London, November 14, "Emotional Development of Childhood"; Dr. E. Eduardo Krapf, professor of medical psychology, University of Buenos Aires, Argentine, November 21, "Psychology of Old Age"; and Dr. Andre Repond, medical director, Maison de Sante de Malevoz, Monthey, Switzerland, November 28, "Psychotherapic Treatment of Mental Disorders".

Faculty Changes.—The following promotions on the faculty of the Chicago Medical School, effective October 1, have been announced by President John J. Sheinin:

Dr. Gordon Cherwitz from instructor to associate in pediatrics.

Dr. Herman L. Eisenberg from instructor to associate in medicine.

Dr. Piero P. Foa from associate professor to professor of physiology and pharmacology.

Dr. Aldo A. Luisada from assistant professor to associate professor of medicine.

Dr. David Presman from associate to assistant professor of urology.

Dr. Jay A. Smith from assistant professor to associate professor of physiology.

Dr. Isadore Spinka from associate to assistant professor of neurology.

Dr. Harry Weisberg from research associate to assistant professor of pathology.

Dr. Ruth Weyl from assistant professor to associate professor of anesthesiology.

Dr. William S. Kroger, assistant professor of gynecology.

KNOX

Society News.—The first regular monthly meeting of the Knox County Medical Society after summer recess was held September 20 in Galesburg. Speakers on the program were Mr. F. Paul Johnson, director of special education, and Mr. John H. Griffith, director of visual education, both of the staff of Galesburg High School. Their presentation was a talk and motion picture showing several types of special education for children with permanent physical handicaps as well as temporary disability.

MADISON

Society News.—Dr. Wendell G. Scott, St. Louis, discussed "Diagnosis of Cerebrovascular and Congenital Cardiac Diseases" before the Madison County Medical Society in Edwardsville, October 4.

MORGAN

Sanatorium Observes Fiftieth Anniversary.—The Norbury Sanatorium, Jacksonville, has this year observed its fiftieth anniversary. A feature of the anniversary was the publication of an illustrated brochure reviewing the history of the sanatorium.

PIKE-CALHOUN

Fifty Year Member.—Dr. A. R. Denny, who practices in Griggsville and Perry, was inducted into the membership of the Fifty Year Club of the Illinois State Medical Society, September 27, at a meeting of the Pike-Calhoun County Medical Society. Dr. Warner H. Newcomb, Jacksonville, Councilor of the Sixth District of the Illinois State Medical Society, presented Dr. Denny with the certificate and pin in honor of his completion of

fifty years of practice as a physician. Prior to opening practice in Griggsville, Dr. Denny, who graduated at the University of Illinois College of Medicine, practiced medicine in Chicago and Galesburg; in Iowa; in Alpine, California; and Quincy.

ROCK ISLAND

Society News.—The September 26 meeting of the Iowa and Illinois Central District Medical Association was addressed in Rock Island by Dr. Justin J. Cordonnier, St. Louis, on "Carcinoma of the Bladder." Dr. James R. Miller, Rock Island, made the introductions and the discussion was opened by Dr. R. D. Perkins, Moline.

WINNEBAGO

Society News.—"Civil Defense and the Medical Society Role in Its Operation" was the theme of a meeting of the Winnebago County Medical Society, October 9. The speakers were Dr. Henrietta Herbolsheimer, deputy director in charge of Civil Defense Health Services of the State of Illinois; and John Gregory, director of civil defense, Winnebago County.

Lectures for the General Practitioner.—The following physicians participated in a group of lectures for the Northern Illinois Regional Chapter of the American Academy of General Practice, in Rock Island: Dr. Robert L. Grissom, assistant professor of medicine, University of Illinois College of Medicine, "Differential Diagnosis and Management of Coronary Heart Disease"; and Dr. George A. Hellmuth, assistant clinical professor of medicine, Stritch School of Medicine of Loyola University, "Differential Diagnosis and Management of Congestive Heart Failure", October 11; Dr. Peter Gaberman, associate professor of medicine, Chicago Medical School, "The Collagen Diseases"; and Dr. Steven O. Schwartz, hematology department, Cook County Hospital, "Differential Diagnosis and Therapy of the Anemias", October 18; Dr. Robert W. Keeton, professor of medicine (emeritus), University of Illinois College of Medicine, "Psychosomatic Aspects of Aging"; and Dr. Max Samter, assistant professor of medicine, University of Illinois College of Medicine, "Allergy in General Practice", October 25.

HEALTH DEPARTMENT ACTIVITIES

Status of Tuberculosis.—The tuberculosis death rate in Illinois has been reduced by more than four-fifths since 1900, according to a state Department of Public Health report. At the beginning of the century, 140 out of every 100,000 persons died of tuberculosis in the state. In 1950 the death rate had been reduced to 25.4 per 100,000. Despite its decline, this disease still ranks as the eighth greatest cause of death in Illinois. It is second only to pneumonia among the fatal communicable diseases. Tuberculosis is a disease which hits hardest at persons in the productive years of life. Of the 2,215 deaths reported as a result of tuberculosis in the state last year, 1,512, more than two-thirds, were among the 25 to 64 age groups. In Chicago, the tuberculosis death rate more than doubles that for downstate Illinois. Last year, Chicago reported 1,447 tuberculosis deaths, or about 65 per cent of the state's total. This gave that city a rate of nearly 40 per 100,000 as against a rate of about 18 for the remainder of the state.

One Per Cent Silver Nitrate Solution Continued.—The Illinois Department of Public Health declared it will continue to approve only the one per cent silver nitrate solution for treatment of eyes of babies at birth. This statement was issued by the department in its weekly bulletin because of pressure from numerous sources advocating the use of penicillin solutions in the prevention of ophthalmia neonatorum, an infection of the eyes contracted during birth which frequently results in blindness. Illinois statutes require prophylactic treatment of the eyes of every newborn baby within an hour after birth. The law provides that "a one percent solution of silver nitrate or some other equally effective prophylactic approved by the state Department of Public Health" be used. Explaining its continued preference of silver nitrate, the department said this agent is a time-proven effective agent, is safe to use, requires only a single application and is very stable when kept in a wax ampule. Penicillin solutions, on the other hand, are unstable, requiring refrigeration and fresh preparation each week, and multiple applications are needed. A person is also likely to develop a subsequent sensitivity to the drug when applied to the eyes, according to the department. "It readily can be seen," the statement said, "that with the shortage of nursing personnel the hazards of attempting to maintain fresh refrigerated solutions of penicillin and administering this in multiple instillations cannot be minimized." The National Society for the Prevention of Blindness has expressed reservations on the adoption of penicillin for treatment of babies' eyes. These came after the society made a careful study of research on the antibiotic treatment conducted at Johns Hopkins hospital, Cornell University medical school, the University of Iowa, the University of Tennessee medical school, Ohio State University and in Trenton, N. J. "The Illinois Department of Public Health will continue to accept one per cent silver nitrate solution as the only approved drug for the prophylaxis of ophthalmia neonatorum until it is convinced that penicillin solutions (or any other antibiotic) can be used throughout the state in both home and hospital with the same degree of safety and effectiveness as silver nitrate," it was stated.

Report on Non-Paralytic Polio Cases.—A rising ratio of reported non-paralytic polio cases in Illinois indicates a possibility that many actually may be cases of other diseases, Dr. Roland R. Cross, state director of public health disclosed recently. Since 1938 there has been general increasing incidence of polio in the state according to disease reports. However, the rate of non-paralytic cases has risen sharp-

ly. Between 1938 and 1945 non-paralytic cases averaged 28 per cent. For the period of 1946 through 1950 the average had risen to 47 per cent. An analysis of the first 832 polio reports for 1951 reveals that 53 per cent are non-paralytic. "It may well be," Dr. Cross asserted, "that admixed with true cases of non-paralytic polio, diseases of the central nervous system similar to polio and including Coxsackie infections account, at least in part, for the upward trend in reports of non-paralytic cases." The Coxsackie infection has most of the early symptoms of polio. However, it is usually mild and the symptoms "transient". In an attempt to determine whether many cases reported as polio are actually that disease or infections by other virus, the state Department of Public Health is conducting studies of cases which have occurred in Champaign county. The reported polio rate in this county has been unusually high this year. Up to Sept. 15, 106 of the state's 930 cases had been reported there. The non-paralytic rate in that county has been 91 per cent. "This leads to the possibility that the majority, if not all the cases of non-paralytic polio in that area were in fact not polio at all but an infection with Coxsackie or other similar virus," Dr. Cross reported. "Laboratory studies on a representative sample have failed to date to reveal either polio or Coxsackie viruses, though work is progressing and other central nervous system viruses remain to be isolated." Dr. Cross said that until simple laboratory tests are developed to differentiate between these diseases the health department will continue to report these as non-paralytic polio.

GENERAL

Advisory Board on Cancer Control.—Governor Adlai E. Stevenson recently announced appointment of one new member and reappointment of two mempers to the Advisory Board to the Bureau of Cancer Control of the state Department of Public Health. Newly appointed to the board is Dr. James M. Christie, surgeon for the Christie Clinic in Champaign. He replaces Dr. James P. Simonds of Chicago. Members reappointed are Dr. Charles L. Leonard, present chairman of the board who is a surgeon on the staff of St. Anthony's Hospital, Rockford, and director of the cancer clinic in that hospital, and Dr. Edwin F. Hirsch, head of the pathological laboratory of St. Luke's Hospital, Chicago. Terms of the members are for three years. Other members of the advisory board to the Bureau of Cancer Control are Dr. James P. Grier, Evanston; Dr. Robert Bowen, Springfield; Dr. R. T. Pettit, Ottawa; and Dr. Gilbert Edwards, Pinckneyville.

Meeting of Chest Physicians.—A joint meeting of the Illinois Chapter American College of Chest Physicians and postgraduate course in diseases of the chest was held September 27. Participating in the X-ray panel of the clinical pathological x-ray conference were Dr. G. C. Turner, Chicago; Dr. I. S. Hirsch, Hines; Dr. L. C. Morris, Chicago; and Dr. D. H. Trumpe, Springfield. Case presentations were made by the following: Dr. L. Levin, Pontiac, Dr. L. Cigarroa, Chicago; Dr. H. Cooper, Hines; Dr. P. Alfano, Chicago; Dr. J. Sagel, Gary; Dr. L. Collins, Edwardsville; Dr. D. Morse, Peoria; Dr. R. Leavitt, Chicago; Dr. G. Zubowicz, Manteno; Dr. L. Latz, Chicago; Dr. W. Bryan, Rockford and Dr. A. Webb, Wheaton. Dr. Charles K. Petter, president of the Illinois Chapter, was moderator; Dr. George W. Holmes, chairman, program committee. Dr. Abel Froman is secretary-treasurer.

Health Talk on TV.—Since the last issue of the ILLINOIS MEDICAL JOURNAL, the following telecasts have been presented by the Educational Committee over WGN-TV, Channel 9, on Tuesday evenings at 7 p.m.:

John A. Mart, October 2, So You've Had a Heart Attack. Standard X-Ray, Cambridge Instrument and Denoyer-Geppert Companies provided equipment for this telecast.

Arthur J. Atkinson, October 9, The Physiology of Digestion, Denoyer-Geppert and Standard X-Ray Companies cooperated in making equipment available.

John J. Brosnan, October 16, Why Take an X-Ray?

George V. Byfield and Howard J. Shaughnessy, Ph.D., chief, division of laboratories, Illinois Department of Public Health, October 23, Undulant Fever. William W. Bolton acted as moderator.

Your Doctor Speaks Over WFJL, Thursday evenings at 7.30 p.m., carried the following transcribed broadcasts under the auspices of the Educational Committee since the last issue of the JOURNAL:

John Elsen, October 4, When Your Ear Aches.
Irving Mack, October 11, Medical Emergencies.
William L. Riker, October 18, Pediatric Surgery.
Walter W. Carroll, October 25, That Lump in Your Breast.

DEATHS

Leslie W. Blackwood, Oak Park, who graduated at the General Medical College, Chicago, in 1923, died September 2, aged 58. He was examining physician for the Pennsylvania Railroad for the past 10 years.

Frank Chauvet, Oak Park, who graduated at the University of Illinois College of Medicine in 1907, died October 3, aged 73. He was associate professor of medicine emeritus at the University of Illinois College of Medicine.

Thomas Walter Cogger, Anna, who graduated at Loyola University School of Medicine in 1919, died in St. John's Hospital, St. Louis, recently, aged 57, of carcinoma of the esophagus.

C. Churchill Croy, retired, formerly of Chicago, who graduated at the College of Physicians and Surgeons, Keokuk, died September 26, aged 81, in Hancock, Wisconsin.

Emile C. Duval, Chicago, who graduated at Chicago Medical School in 1919, died October 10, aged 77. He was a past president of the Chicago Industrial Surgeons Society.

Tally J. Echerer, Chicago, who graduated at Chicago College of Medicine and Surgery in 1916, died October 9, aged 56. He was on the surgical staffs of the Francis Willard and Loretto Hospitals.

Clifford W. Emons, Alton, who graduated at St. Louis University School of Medicine in 1924, died September 13, aged 52.

Edgar W. Gardner, Downers Grove, formerly of Chicago, who graduated at Keokuk Medical College, College of Physicians and Surgeons, in 1906, died September 6, aged 67. He had practiced in the field of otolaryngology over 30 years.

George Boris Hassin, Chicago, who graduated at the University of Kazan Faculty of Medicine, Russia, in 1897, died August 15, aged 77, of cerebral hemorrhage. He was professor of neurology emeritus at the University of Illinois College of Medicine.

Richard Louis Joseph Kemel, Chicago, who graduated at the Université Catholique de Louvain Faculté de Médecine, Belgium in 1902, died July 18, aged 75, of arteriosclerotic heart disease.

Herman Louis Kretschmer, Chicago, who graduated at Northwestern University Medical School in 1904, died September 23, aged 72, of acute ventricular failure. He became clinical professor of surgery at Rush Medical College, urologist at Presbyterian Hospital, consulting urologist to the Children's Memorial Hospital, and was on the staff of the Veterans Administration Hospital in Hines, Ill. In September, 1945, he became clinical professor of urology at the University of Illinois College of Medicine, serving until September, 1947, when he became clinical professor of urology, emeritus.

Graham M. Lisor, Elgin, who graduated at Barnes Medical College, St. Louis, in 1911, died August 30, aged 63. He was a staff member of the Sherman and St. Joseph Hospitals.

Michael F. McGuire, Chicago, who graduated at National University of Ireland, Dublin, in 1911, died September 26, aged 63. He was clinical professor of surgery at Stritch School of Medicine of Loyola University.

William Pierce, Chicago, who graduated at Washington University School of Medicine, St. Louis, in 1903, died July 6, aged 77, of acute coronary thrombosis.

Andrew Roble, Chicago, who graduated at Northwestern University Medical School in 1924, died September 26, aged 56.

Annie White Sage, retired, Chicago, who graduated at Northwestern University Woman's Medical School in 1890, died September 17, aged 92.

Martin A. Schupmann, Chicago, who graduated at Bennett Medical College, Chicago, in 1909, died September 20, aged 64. He was attending surgeon at Roosevelt Hospital.

Herman M. Schwerer, Canton, who graduated at the University of Illinois College of Medicine in 1934, died October 13, aged 44, of coronary thrombosis. He practiced medicine first in Blandinsville, then Lewistown, and in 1942 he became associated with the Coleman Clinic in Canton. He was chairman of the Fulton County Tuberculosis Association and on the staff of the Graham Hospital of Canton as chief of the cardiology section.

Oliver Z. Stephens, Stewardson, who graduated at Northwestern University Medical School in 1904, died August 17, aged 81, of myocarditis.

Richard Kronenberger, Chicago, who graduated at Northwestern University Medical School in 1948, died October 8, aged 32.

Arnold Dwight Tuttle, retired, Chicago, who graduated at University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, in 1906, died October 6, aged 70. He had been a colonel in the U. S. Army, and medical director of United Air Lines.

Joseph G. Weber, Chicago, who graduated at Bennett Medical College, Chicago, in 1915, died September 27, aged 68. He had practiced medicine in the field of otolaryngology for 34 years.

James H. Williamson, Danville, who graduated at Missouri Medical College, St. Louis, in 1898, died September 9, aged 79, of carcinoma of the kidney. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Benjamin Maurice Wolin, Chicago, who graduated at Bennett Medical College, Chicago, in 1915, died July 7, aged 61, of bronchogenic carcinoma.

Paul H. Wosika, Chicago, who graduated at Northwestern University Medical School in 1931, was killed September 8 in an air crash near Crete. He was 46. He was associate professor of medicine at Chicago Medical School.

Thaddeus Z. Xelowski, Chicago, who graduated at the University of Illinois College of Medicine in 1903, died August 30, aged 74. He had been on the staff of St. Mary's Hospital since 1905.

John Henry Yount, Chicago, who graduated at Vanderbilt University School of Medicine, Nashville, in 1906, died June 6, aged 67.

"FOR THE COMMON GOOD"

Lectures Arranged Through the Educational Committee:

Adrian D. M. Kraus, Chicago, October 12, Arbor Park P.T.A., in Oak Forest, Health of the School Child.

Jeanne K. Mercer, Oak Park, November 5, Divine Infant Guild of the Tabernacle, in Westchester, Infant Feeding.

Edward W. Cannady, East St. Louis, November 8, Tenth District, Illinois State Nurses' Association, in Highland, Advances in Medicine.

Joseph Freilich, Chicago, November 16, Mary Lyon P.T.A., It's Your Health!

Miss Ann Fox, Secretary, Educational Committee, November 20, Woman's Auxiliary to the Jackson Park Branch of the Chicago Medical Society, There's No Business Like Medical Business!

Lectures Arranged Through the Scientific Service Committee:

Carlos I. Reed, Ph.D., Chicago, October 5, Conference on Nutrition, under the auspices of the Greene County Medical Society, in White Hall, Soil Conservation and Nutrition.

Sam Kruger, Hines, October 9, Rock Island County Medical Society, in Rock Island, Treatment of Atomic Casualties.

Marc Hollender, Chicago, October 11, Champaign County Medical Society, in Champaign, The Psychologic Approach to Everyday Problems in Medicine.

Edmund A. Gorvett, Chicago, October 17, Du Page County Medical Society, Elmhurst, The Management of the Gastric Ulcer.

Frank V. Theis, Chicago, October 17, Kane County Medical Society, Elgin, Peripheral Vascular Disease: Improved Outlook for Conservatism, Illustrated.

Theodore R. Hudson, Chicago, October 18, La Salle County Medical Society, Ottawa, The Surgical Treatment of Mitral Stenosis, illustrated.

Adrien Ver Brugghen, Chicago, October 26, Whiteside-Lee County Medical Societies, Rock Falls, Cranial Injuries, illustrated.

George M. Cummins, Chicago, November 8, Henry County Medical Society, in Kewanee, Some Cardiovascular Aspects of the Aging.

William L. Riker, Chicago, November 8, Champaign County Medical Society, Champaign, Correction of Congenital Anomalies.

Louis Feldman, Chicago, November 15, La Salle County Medical Society, La Salle, Modern Treatment of Subacute Bacterial Endocarditis.

George A. Hellmuth, Chicago, November 15, Stock Yards Branch of the Chicago Medical Society, Evangelical Hospital, Clinical Correlation of Electrocardiography in Practice, illustrated.

Charles J. Smith, Chicago, November 20, Iroquois County Medical Society, Watseka, Anesthetics and Analgesics in Obstetrics, illustrated.

Willard O. Thompson, Chicago, November 21, Du Page County Medical Society, Elmhurst, Clinical Applications of Sex Hormones, illustrated.

Irwin R. Callen, Chicago, November 23, McDonough County Medical Society, Macomb, Coronary Disease.

LIFE ENDANGERING HEMORRHAGE

There are no advances in the surgical management of peptic ulcers which are bleeding seriously. It is true that experienced surgeons working in institutions which provide excellent anesthesia and enthusiastic and mature preoperative and postoperative care have progressively lower mortality rates in these cases each year. However, it is still impossible to make scientific decisions on a certain number of cases with life endangering hematomesis because the source of the bleeding is in doubt and because in more than 90 per cent of the cases, the bleeding will stop without surgical intervention. The literature is difficult to evaluate because of the varying criteria of "severe" hemorrhage. Since there are no definite criteria to separate those cases in which bleeding will stop from those cases in which it will not stop and since the patient's chances of surviving operation will depend upon the facilities at hand, every case will have to be individually evaluated. *Excerpt: The Surgery of Peptic Ulcer, B. L. Sinner, M.D., St. Louis. J. Missouri M.A., July,* 1951.

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The mild, calming sedation of *phenobarbital*—to ease tension, to quiet nervousness. High dosages of *thiamine*—to restore appetite and improve general nervous tone.

now in 2 dosage forms:

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New Eskaphen B Tablets—This is the convenient alternate dosage form.

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Each 5 cc. teaspoonful of the Elixir contains phenobarbital, ¼ gr.; thiamine hydrochloride, 5 mg. Each tablet is the dosage equivalent of 5 cc. of the Elixir.



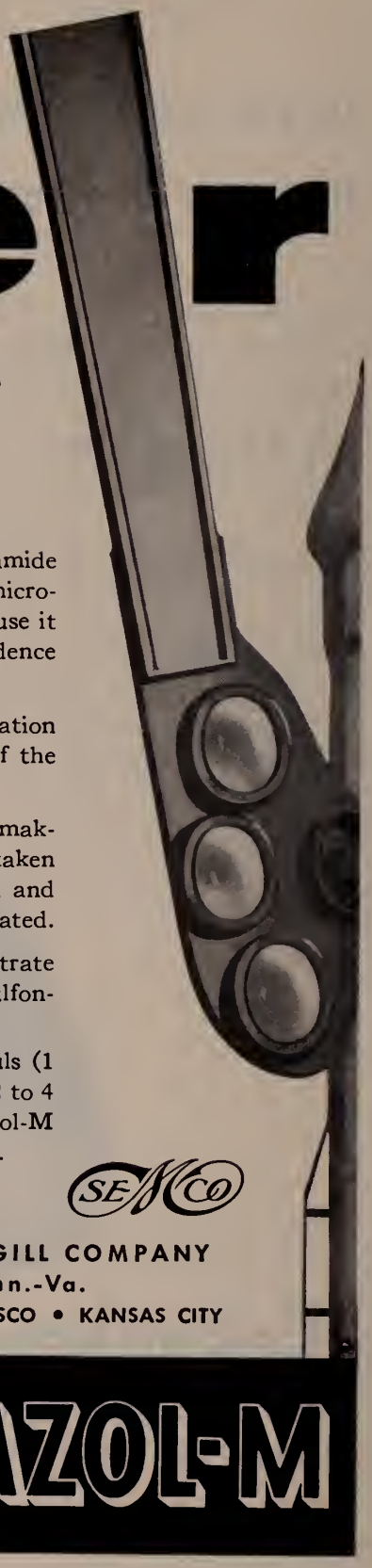
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Aldiazol-M brings a high degree of safety to sulfonamide therapy. This alkalizing suspension of equal parts of microcrystalline sulfadiazine and sulfamerazine is safer because it decreases the danger of crystalluria and reduces the incidence of allergic reactions. It offers these advantages:

Greater Efficacy, achieved through decreased acetylation of the absorbed sulfonamides, and rapid absorption of the microcrystalline form.

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Discharge and malodor of bacterial cervicitis and vaginitis can be markedly decreased by Furacin Vaginal Suppositories.

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These suppositories are indicated for bacterial cervicitis and vaginitis, pre- and postoperatively in cervical and vaginal surgery.

Literature on request



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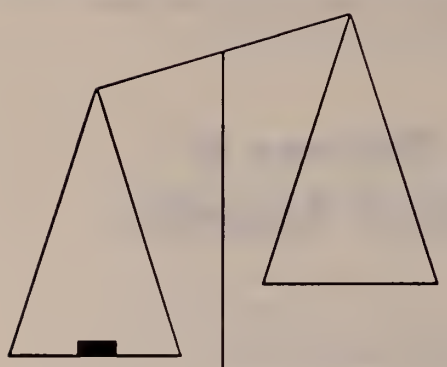
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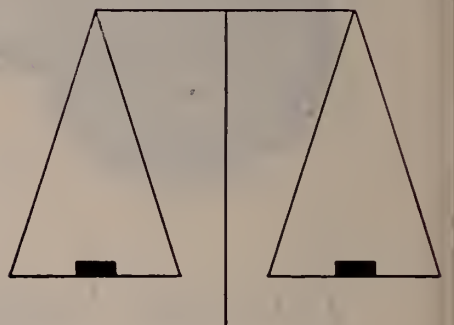
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'Resodec' for sodium control

not a diuretic! not a salt substitute!



Sodium imbalance causes edema



'Resodec' restores sodium balance

What it is: 'Resodec' is a remarkable new substance* that has the ability to remove excess sodium from the contents of the intestinal tract and to carry it out of the body in the feces. Hay, M. D., and Wood, J. E., Jr.: Ann. Int. Med. 33: 1139 (Nov.) 1950.

What it does: 'Resodec' produces the approximate effect of *halving* the patient's salt intake—thus assuring adequate sodium control, with a minimum of dietary restriction.

For complete details, dosage directions and contraindications, see professional literature—available upon request.

the first **positive** means of achieving adequate sodium control in **congestive heart failure**

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Another report* of **'Resodec'** therapy

in a congestive heart failure case

(average reading time: 2 minutes)

"NAME: Patient E.R.C. HISTORY No.: 50946

AGE: 67 – Male

DIAGNOSES: Hypertensive heart disease, cardiac enlargement, auricular fibrillation, and intermittent congestive heart failure, questionable rheumatic heart disease with mitral insufficiency co-existing."

RESULTS: "In retrospect this patient has obviously benefited from 'Resodec' supplementing his low-sodium diet. In spite of digitalization, salt restriction, and frequent injections of mercurial diuretics between January of 1945 and May of 1950, he had had difficulty in remaining compensated, had not been able to work, and had been dyspneic and edematous during most of this period.

"Since the second week of 'Resodec' therapy, however, he has required no further mercurial diuretics, and following the sixth week of resin therapy his digitalis was reduced from .9 to .7 weekly. After losing his edema over an initial three-week period, his weight has remained fairly constant at about 145 pounds. His blood pressure has been reduced somewhat, particularly the diastolic....

"He has felt much better during this period of therapy, has been able to do light work about his house, and resume activity which was previously denied him. This patient is particularly enthusiastic regarding 'Resodec' therapy and wishes to continue it indefinitely. He has noted no side effects to the 'Resodec' therapy and has not found it unpleasant to taste....

"He is at present on an intake of 450 mg. of sodium daily, calcium gluconate, two teaspoonfuls twice daily, 'Resodec' 45 Gm. daily, digitoxin .1 mg. daily, and no other medication."

*Excerpts from an actual case history, as reported from a leading medical institution.

Adequate Protein Nutrition... A Vital Factor in Recovery Processes

Among the problems of convalescence and of preoperative and postoperative care, adequate protein nutrition assumes vital importance. Such is indicated by the observation that a deficiency of but one essential amino acid in the diet of the normal individual quickly leads to an acute amino acid deficiency syndrome characterized by appetite failure, weight loss, and malaise.

Animal studies have forcefully demonstrated the adverse effect of inadequate protein nutrition on recovery processes.[1] Protein-depleted rats fed an adequate repletion ration manifest a rapid recovery of lost weight, of normal plasma protein and hemoglobin levels, of certain enzyme systems, and of normal capacity to synthesize antibody protein and to resist infection. On the other hand, reduction in the amount of but one essential amino acid in the repletion ration quickly causes loss of appetite, diminished food consumption, and inadequate weight recovery. This quick appearance of overt symptoms due to a shortage of an essential amino acid contrasts sharply with the delayed appearance of symptoms induced by deficient intake of any other essential nutrient.

These manifestations of acute amino acid deficiency noted in the rat can occur as readily in the normal human subject consuming a diet lacking in any one of the eight essential amino acids.[2] Loss of appetite and of body nitrogen accompanied by malaise quickly results. Furthermore, addition of the missing amino acid to the diet quickly restores the appetite, nitrogen equilibrium, and the previous state of health. Apparently, even in normal persons, lack of an amino acid in the diet partially or completely interrupts protein synthesis as well as increases tissue protein catabolism.[1] The conclusion is incontestable, therefore, that adequate protein nutrition is vital for speeding the processes of recovery from massive disease or major surgery.

Meat—all varieties and cuts—richly provides protein containing all the essential amino acids which are needed for the repair of traumatized tissue, the upkeep of normal tissue, and for other vital uses. Furthermore, meat is a dependable dietary source of iron and the vitamin B complex—riboflavin, niacin, thiamine, pyridoxine, and the newly discovered B_{12}. In health and in illness, meat ranks high as an important factor of the well-balanced diet.

1. Cannon, P. R.: Recent Advances in Nutrition with Particular Reference to Protein Metabolism, Lawrence, Kansas, University of Kansas Press, 1950, pp. 56-60.

2. Rose, W. C.: The Nutritive Role of the Amino Acids, The Science of Nutrition, New York, The Nutrition Foundation, 1946.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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Full Codeine Effects...

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By utilizing the principle of synergistic enhancement in its fullest logical form, Phenaphen with Codeine provides *high* analgesia and sedation on relatively *low* codeine dosage, with reduced side-effects. The analgesics (aspirin 2½ gr. and phenacetin 3 gr. per capsule) and sedative (phenobarbital ¼ gr.) effectively potentiate a small dosage of codeine (either ¼ or ½ gr.). And the addition of the spasmolytic hyoscyamine (0.031 mg.) —to implement the analgesic-sedative action, and to help counteract any tendency to nausea or constipation so often provoked by codeine medication—provides a combination that has "proved practically always successful" for patients with steady pain.

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Treatment of most pruritic dermatoses is enhanced if the therapeutic agent is permitted to act on the primary pathology unhampered by mechanical irritation. Conscious or involuntary scratching and secondary infection which often follows, obstructs the therapeutic effect of the healing agent.

HISTAR provides vital symptomatic relief of the itching, swelling, and burning, and simultaneously attacks the causative condition. This is possible because HISTAR is a combination of a proven antihistaminic (pyrilamine maleate 2%) which produces this symptomatic relief and a clinically effective special process extract of coal tar 5% (Tarbonis brand) which combats the dermatosis itself.

FOR PRESCRIPTIONS—all pharmacies stock 2 oz. jars; FOR DISPENSING PURPOSES—1 lb. jars through your surgical supply house.

1. *Walters, J.D. and Gilman, R.L.:* A Combination of Tar and Antihistaminic for Local Use; *U. S. Armed Forces Med. J.: 2:187 (Feb.) 1951.*

HISTAR has proved especially effective in neurodermatitis[1] and eczema (infantile, contact, etc.). Its broad dermatological spectral also includes: Pruritus ani, psoriasis, atopic dermatitis, impetigo, diaper rash, lichen simplex chronicus, and bacterial ids.

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permitting
early re-alimentation and hydration
by the oral route[1]

Recent studies[1,2] have demonstrated the unusually dependable value of Arobon in acute diarrheas of infants and children. Within a matter of one to two days, in the majority of patients the stools thicken and lessen in frequency. Thus early re-alimentation and hydration by the oral route and earlier resumption of normal feeding are possible.

Arobon, processed from carob flour, owes its pronounced anti-diarrheal activity primarily to its high content of lignin as well as pectin. Absorbing a considerable amount of water, it swells to a bland, smooth, bulky mass in the intestine, which eliminates offending bacteria and toxins with the stools, thus causing the diarrhea to subside quickly.

Arobon is indicated in all types of diarrhea in infants and children. It is palatable and readily tolerated. Arobon is ready for use by merely boiling it in water for ½ minute.

1. Smith, A. E., and Fischer, C. C.: The Use of Carob Flour in the Treatment of Diarrhea in Infants and Children, J. Ped. *35:*422 (Oct.) 1949.
2. Kaliski, S. R., and Mitchell, D. D.: Treatment of Diarrhea with Carob Flour, Texas State J. Med. *46:*675 (Sept.) 1950.

THE NESTLÉ COMPANY, INC.
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HIGH IN PECTIN
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a NEW strength of 'Eskacillin':

'Eskacillin 250'

250,000 units of procaine penicillin G per teaspoonful

effective with only 3 doses daily

why 'Eskacillin 250' contains procaine penicillin:

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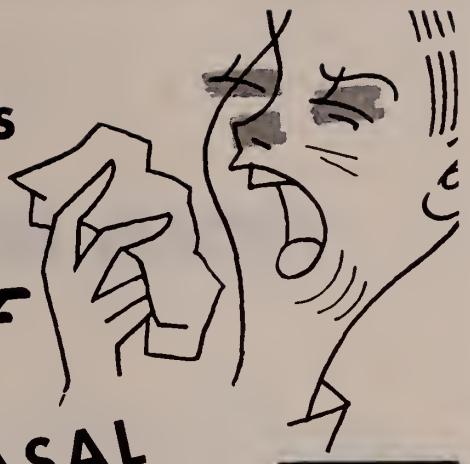
c. Rapid absorption. Although procaine penicillin is absorbed slowly when given parenterally, it is absorbed rapidly from the gut.

Now there are 3 strengths of 'Eskacillin': 'Eskacillin 250' (new); 'Eskacillin 100', containing 100,000 units of penicillin per 5 cc. (1 teaspoonful); and 'Eskacillin 50', containing 50,000 units of penicillin per 5 cc. (1 teaspoonful). All are available in 2 fl. oz. bottles.

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'Eskacillin' T. M. Reg. U. S. Pat. Off.

IN NASOPHARYNGITIS HERE IS *PROMPT RELIEF*



BACITRACIN-NASAL

Bacitracin-Nasal provides 250 units of bacitracin per cc. and 0.25% of *dl*-desoxyephedrine hydrochloride in a buffered, isotonic, rose-scented solution. In addition to the effective local antibiotic action of bacitracin, it also provides prompt relief by the vasoconstriction produced by *dl*-desoxyephedrine hydrochloride. Bacitracin is virtually nonallergenic and, further, no inhibitor similar in action to penicillinase has been demonstrated.* Bacitracin-Nasal may be administered by dropper or nebulizing spray to relieve congestion quickly and to shorten the duration of infection in nasopharyngitis.



**Prigal, S. J., and Furman, M. L.: The Use of Bacitracin, a New Antibiotic, in Aerosol Form; Preliminary Observations, Ann. Allergy 7:662 (Sept.-Oct.) 1949.*

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Each Bacitracin Troche combines the antibiotic action of 1,000 units of bacitracin with the local anesthetic effect of 5 mg. of benzocaine. Bacitracin Troches are candy-flavored. Their pleasant taste and soothing effect readily adapts them for collateral treatment in nasopharyngitis.

SUPPLY: Bacitracin-Nasal is supplied as a dry powder, to be diluted and dispensed by the pharmacist in a ½ ounce bottle provided for this purpose.
Bacitracin Troches are supplied in bottles of 25. Refrigeration is not required.

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PHYSICAL MEDICINE ABSTRACTS



THE PREVENTION OF THROMBOEMBOLISM

Leo Loewe, M.D., Louis Berger, M.D., and Richard P. Lasser, M.D. In ANGIOLOGY, 2:1:26, February 1951.

This communication is intended to discuss the problems of thromboembolic disease in general; to review, critically, the various measures now employed in dealing with the disease and to recount our experience with a comprehensive prophylactic program. This will serve to emphasize the importance of a prophylactic approach rather than a purely therapeutic one and will demonstrate that a large scale prophylactic effort is both fruitful and feasible.

Several non-specific measures in the prevention of venous thromboembolic disease are, generally, in surgical patients. One of these is early ambulation. This means not merely dangling but actually getting the patient out of bed. The heels, only, are to be supported by a soft foot stool. The calves should not be in contact with anything; in other words, there should be an avoidance of pressure on the calf veins. Patients should actually be ambulated on the day of operation and preferably immediately or as soon after the operation as possible. This can be done with but few exceptions. It is an erroneous idea that patients who are merely gotten out of bed and permitted to sit for an undetermined period of time are ambulated. This, in point of fact, is worse than permitting the patient to be in bed throughout. Early ambulation is associated with a reduction in the incidence of thromboembolic disease from 53 to 18 per cent and especially is the incidence of pulmonary embolism reduced. These statistics may be, of course, somewhat overenthusiastic in that many of the reported series do not take into consideration the delayed type of thromboembolic disease which makes its appearance after the patient's discharge from the hospital. We know of instances of this type, and are convinced that others have encountered the same. While early ambulation alone does not solve the problem in its entirety, the fact, nevertheless, remains that both the morbidity and the mortality are decidedly reduced.

Elevation of the legs and leg exercises are helpful but the beneficial effects are not too significant. Exercises in bed are nevertheless recommended.

Avoidance of compression of calf veins, especially in elderly subjects, is an important detail. This applies to the procedures in the operating room as well as postoperatively.

In patients with varicose veins, elastic stockings and other pressure dressings are of some value. However, severe compression of varicose veins in elderly subjects is contra-indicated.

Such general measures can be carried out regularly except in the aged, the desperately ill, those with advanced malignancy and the bed-fast.

(*Continued on page* 68)

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RUBRAGRAN FORMULA	1 capsule supplies	1 capsule t.i.d. supplies
Vitamin B_{12}	25 mcgm.	75 mcgm.
Folic Acid	1.67 mg.	5 mg.
Ascorbic Acid	100 mg.	300 mg.
Iron (elemental)	67 mg.	200 mg.
(as ferrous sulfate exsic.)	230 mg.	690 mg.
Desiccated Liver	100 mg.	300 mg.

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Because of the serious nature of the disease, true addisonian pernicious anemia should not be treated with oral preparations. Parenteral Rubramin or Liver Injection should be used.

'RUBRAGRAN' IS A TRADEMARK OF E. R. SQUIBB & SONS

SQUIBB

Physical Medicine (Continued)

TENDINITIS AND SUBACROMIAL BURSITIS

K. Armand Fischer, M.D., and Kenton D. Leatherman, M.D., Louisville, Ky. In THE JOURNAL OF THE KENTUCKY STATE MEDICAL ASSOCIATION, 49:7:296, July 1951.

Conservative treatment usually suffices in the ordinary case of acute tendinitis and subacromial bursitis. Sedation is necessary because most patients have considerable pain and loss of sleep. The usual patient keeps his arm adducted to his side in order to splint it, and a measure which will relieve pain quickly is the placing of the arm on pillows away from the chest at 90 degrees or placing the arm on an abduction splint. Frequently this relieves pain in itself.

Hot moist packs seem to be most beneficial for relief of pain and one should use them whether a patient is in bed or wearing an abduction splint, or keeps his arm abducted on the side of the bed or table. In very painful cases hot moist packs should be kept on 24 hours a day except when certain exercises are taken. In ambulatory cases that have mild pain novocaine injections of one or two per cent solution into the region of the bursa will temporarily relieve this pain and then circumduction and pendulum exercises can be started in order to bring about a complete range of motion in the shoulder. These exercises should be done hourly.

Aspiration and needling of a calcium deposit after injection of novocaine is another popular method of treatment. After such an irrigation a shoulder manipulation should be done and the patient given instructions in circumduction exercises. This type of treatment is best carried out in a hospital because the pain returns after the needling and the patient should be near where plenty of sedation can be given. Cold packs are used for 24 hours and this should be followed by moist hot packs and the exercising routine. An exercise routine should be used in every case no matter what type of treatment has been used, and when resting, the arm should be placed in abduction, either on a splint or pillow. Pendu-

(*Continued on page 70*)

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1... relaxation of smooth muscle spasm especially of the genito-urinary and gastro-intestinal tracts
2... in migraine and related headaches.

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lum exercises are easy to do and they are not contraindicated in any type of bursitis. After a few trials then the patient can do circumduction exercises and one should instruct them that the more they do them the sooner they will lose the pain. In the sitting position we try to have them put their hand behind their head to improve external rotation of the shoulder, and when standing they should place their hand behind their back for internal rotation of the arm.

X-ray therapy is beneficial to acute cases and some subacute cases. So often with the use of X-ray therapy the patient is not given exercises or hot packs. It is very necessary to use some type of heat and exercises following X-ray therapy or stiffness of the shoulder may ensue in spite of relief of pain. The acute symptoms of bursitis usually pass away in from 5 to 7 days and even after that the exercise routine must be kept up and the arm be abducted on a pillow while in bed. It usually is necessary to continue the circumduction exercises, placing the hand behind their head and behind their back for a period of several months time. It is well after the first week to use some dry heat in the form of infrared ray on the shoulder before exercising when possible. Until a normal range of motion has been established in the shoulder, exercises and even stretching of the tight shoulder is necessary.

Surgery is indicated in some cases of acute tendinitis with subacromial bursitis. At the time of surgery the shoulder is manipulated in all directions, and following the operation the arm is placed in an abducted position. Circumduction exercises and pendulum exercises are started within 24 hours and the patient is out of bed to do this. He is advised to sit beside his bed, keep his arm abducted on pillows and then put his hand behind his head when sitting down, and on standing to put his hand behind his back so that internal and external rotation can be promoted. Patients with subacute and chronic symptoms of bursitis extending over a period of 6 to 8 weeks

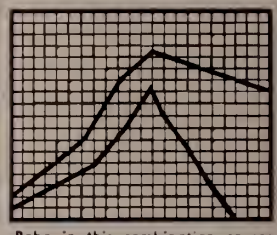
(Continued on page 72)

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Pabirin causes a salicylate blood level increase of two to five, and in rheumatic fever, produces an effective level of 35 mg. per 100 cc. For this result, less of the Pabirin mixture is required than of a single salicylate. *In cases where sodium restriction is indicated, Pabirin is favored over other salicylate combinations.*

The most important factor in Pabirin's maintenance of salicylate blood levels, probably, is *the synergistic action of para-aminobenzoic acid upon the salicylate.* By replacing sodium salicylate with aspirin, and including para-aminobenzoic acid, which tends to produce an acid urine, Pabirin *decreases the urinary output of salicylate. Thus higher blood levels of salicylate are assured with Pabirin than with a salicylate alone.*

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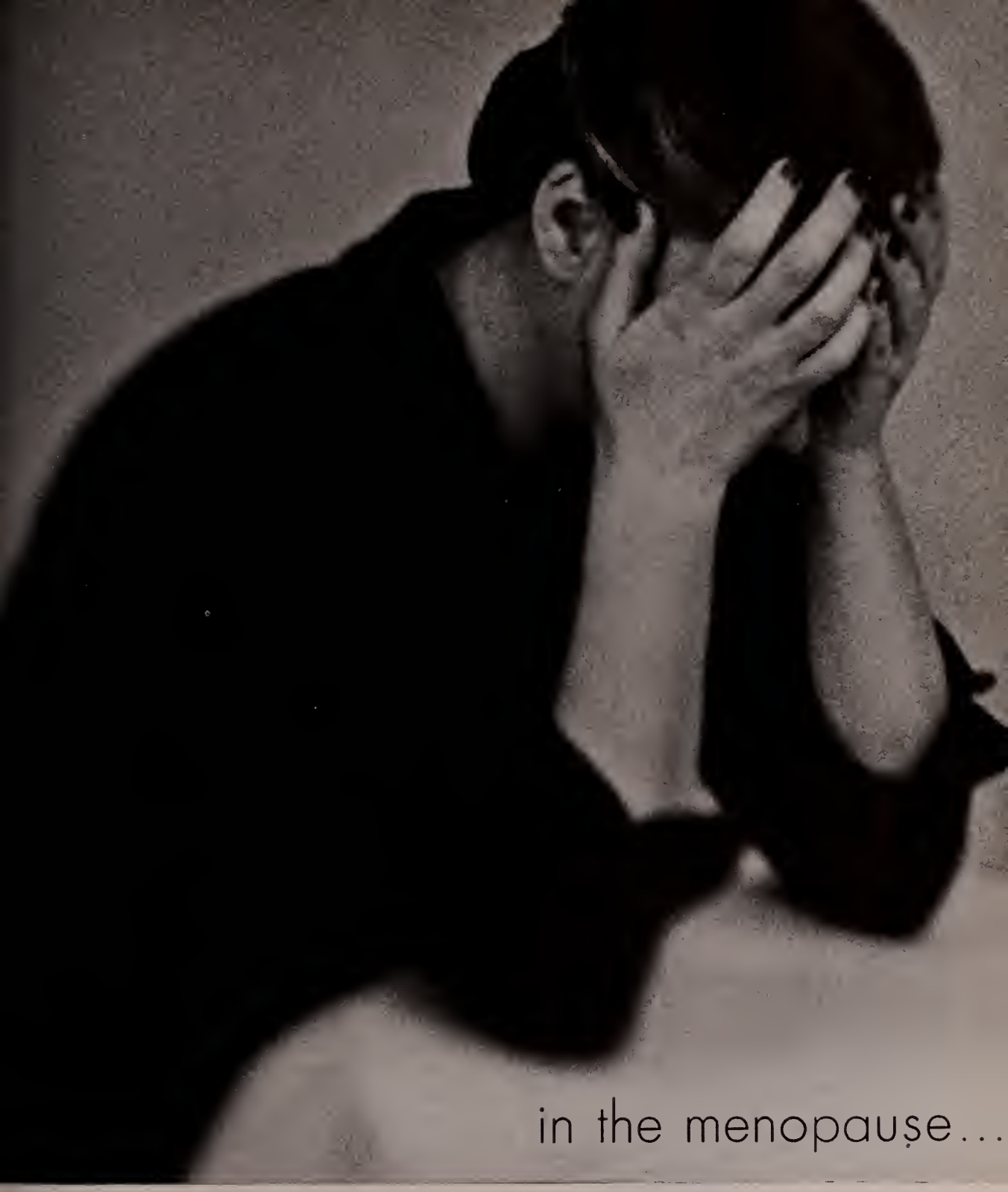
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in the menopause...

"all patients described a sense of well-being [with 'Premarin'].''

Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943

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Physical Medicine (Continued)

usually have their arms immobilized to their side and thus present a more difficult problem to treat. At times they are very miserable persons due to pain and sometimes addiction to opiates is present when the orthopedist sees the patient. Usually at this period they can not tolerate much pain and they have to be handled gently. This type of patient should be near where he can receive physical therapy twice a day, or he should enter a hospital for treatment. Then infra-red heat or hot moist packs can be used to relieve pain so that exercises and stretching can be started. One must explain to these patients what has taken place in their shoulder with resulting adhesions and tightness in the tendons and muscles around the shoulder. They must be taught how to keep their arm away from their side on pillows or on an abduction splint. Pendulum exercises are begun gently at first and then more energetically later. Wall climbing and other exercises are instituted and by massage and gentle stretching over several weeks time the shoulder motion can be increased and pain will gradually be gone. As the shoulder loosens the patient becomes more free of pain. At times they have pains in the side of the neck radiating down the arm and forearm into the little finger.

Manipulation of shoulders in subacute and chronic bursitis cases under an anesthetic has been used at times. A complete range of motion is sought by stretching the shoulder in several directions. Following the manipulation the patient has a great amount of pain, and an ice bag must be placed on the shoulder and the arm kept in an abducted position with traction on the arm. As soon as possible the patient must be assisted out of bed and exercises started. Then the patient can sit beside the bed and place the arm on pillows on the bed in an abducted position. At hourly periods pendulum and circumduction exercises are continued. Hot packs or infra-red heat is used on the shoulder preliminary to the exercises for relief of pain. The exercises must be kept up energetically otherwise the shoulder stiffens just like it was before the manipulation.

Treatment of these hospital patients must be continued for several months following the manipulation. They should be in the hands of a competent physical therapist and the physician

(*Continued on page* 74)

When the diagnosis is Pyelitis

First: consider



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To establish and maintain urinary antisepsis, MANDELAMINE* is many times preferred because it is quickly effective against the organisms most commonly encountered in urinary-tract infections. Its exceptional freedom from untoward reactions and its wide range of antibacterial activity commend it for use as soon as the diagnosis has been made.

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Other indications for MANDELAMINE are cystitis, prostatitis, pyelonephritis, nonspecific urethritis, and infections associated with urinary calculi or neurogenic bladder; also valuable for pre- and postoperative prophylaxis in urologic surgery.

Renal insufficiency is the only major contraindication to MANDELAMINE therapy.

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should see them almost daily to impress upon them the necessity of hourly exercises and a heat routine at home. The more chronic patients will have to exercise sometimes for a period of 6 to 12 months before a complete range of motion has returned and the pain in the neck, hand and arm is relieved.

ADMINISTRATIVE PROBLEMS IN A POLIO UNIT

Sister M. Assumpta, O.S.B., Administrator, Hibbing General Hospital, Hibbing, Minn. In HOSPITAL PROGRESS, 32:6:170, June 1951.

In considering facilities for convalescent care, we should discuss the use of physical therapy facilities such as exercise tables, practice mats, parallel bars, training steps, crutches or walking sticks, wall mirrors, etc. In other words, an administrative problem of the hospital would be to provide the space for this equipment, allowing ample room for its appropriate use. Some hospitals might make provision for the Hubbard tank or other type of treatment pools, although these are not always necessary. An ordinary bathtub could be used in the convalescent ward.

One physical therapist usually can take care of about six acutely ill polio patients but there is wide latitude depending upon the severity of involvement. If there is not too much involvement, a physical therapist will be able to take care of more patients during the acute stage. During convalescence, a physical therapist can take care of approximately 12-15 patients in a ward. One physical therapist can take care of 15 to 20 out-patients daily, depending upon the amount of involvement they have. Obviously, when complete muscle evaluations are done, the number will be less. These figures are necessarily flexible and, unfortunately, all too often a heavy case load increases the burden on any individual therapist beyond the desired ratio.

Under therapeutic services, we should discuss

(*Continued on page* 76)

More than just estrogen therapy...

...THIS COMBINATION HELPS RESTORE ENERGY, FITNESS AND A SENSE OF WELL-BEING

SEStramin (PATCH)

—goes beyond the provision of estrogen sufficiency—it treats also the patient's nutritional state by providing a balanced estrogen-vitamin formula.

Sestramin is indicated in natural and surgical menopause, functional amenorrhea and dysmenorrhea, suppression of lactation.

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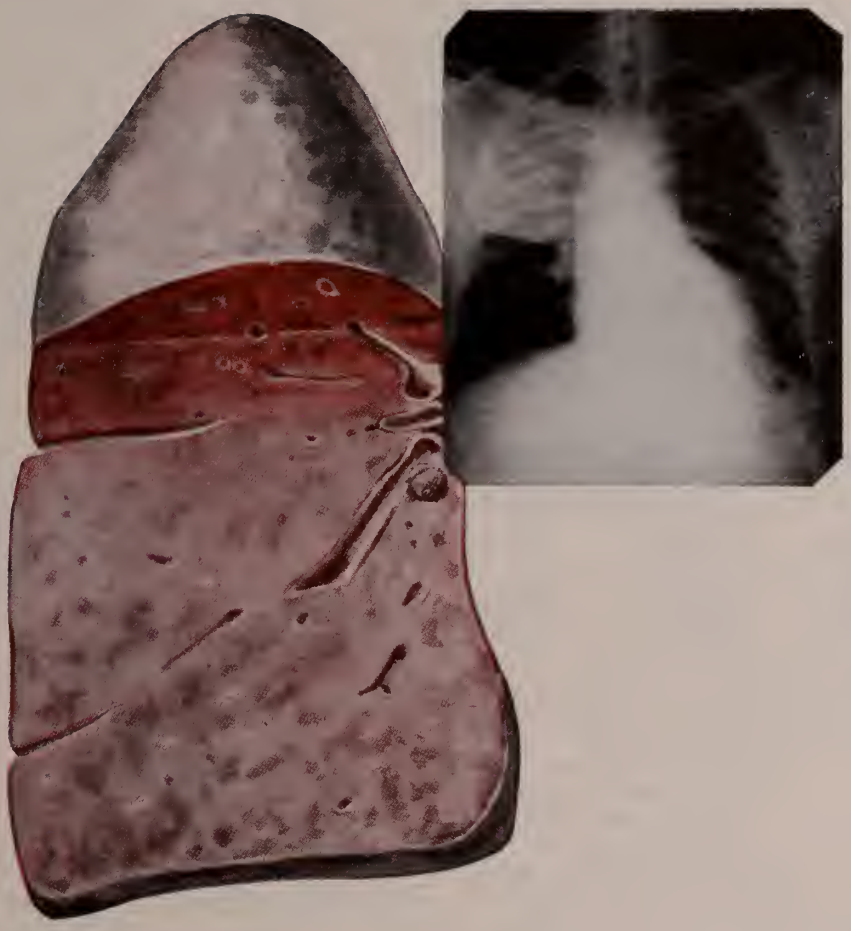
SEStramin 10M—Conjugated estrogens equivalent to oral activity of Sodium Estrone Sulfate 1.25 mg.

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Formulae: Brewers' yeast, 100 mg.; Thiamine hydrochloride, 3 mg.; Riboflavin, 2 mg.; Niacinamide, 10 mg.; Pyridoxine hydrochloride, 1 mg.; Calcium pantothenate, 5 mg.; Ascorbic acid (vitamin C), 25 mg.; Vitamin D, 500 I.U.

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Potterfield, T. G., and Starkweather, G. A.: J. Philadelphia General Hosp. 2:6 (Jan.) 1951

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Relationship of Stress to Autonomic Lability

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance. [1,2] Such states may involve any one of the organ systems or several at one time. [1,3] The outline below relates gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifesta-tions	Palpitation Tachycardia Elevated B. P. Dry mouth—throat	Heartburn Nausea-vomiting Low B. P. Colonic spasm

Data here tabulated is from references [3,4,5,6,7], given below.

Diagnosis of functional disorder is supported by the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relief of symptoms by drug therapy (so making the patient more amenable to psychotherapy); 2) psychotherapeutic guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

Clinicians who have studied these disorders, including those of the menopause, report that good therapeutic results are produced by combined adrenergic (ergotamine) and cholinergic blockade (Bellafoline) with central sedation (phenobarbital) [8,9,10]. A convenient preparation of this nature is available in the form of **Bellergal Tablets.** Functional disorders are long-term therapeutic problems; therefore, drug treatment by the following method is recommended: 5 or 6 tabs. per day for the 1st week; then gradually reduce to the smallest dose effective in maintaining the patient symptom free (average: 3 tabs. daily). Interrupt for 1 week out of every month to assess results.

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Physical Medicine (Continued)

the treatment of the patient during the acute phase of the illness with the proper use of nursing, physical therapy, hot packs, warm pools, respirators, rocking bed, etc.

It should be remembered that there is nothing magic or curative about the hot packs. The degree of remaining muscle paralysis depends upon the number of anterior horn cells (motor nerve cells) that are destroyed by this virus. It is acknowledged that moist heat, either in the form of hot packs or warm pool treatments, does relieve muscle pain and when this is accompanied or followed by gently passive and later active exercises, the flexibility of muscles and joints is maintained more easily. Naturally, heat should not be applied while the patient is still running a high fever, but should be started as promptly as possible. Hot packing should be cautiously used on weakened patients during hot weather.

The roles of the occupational therapist, medical social worker, and public health nurse should also be discussed.

Special treatment should be given to the bulbar type patient, stressing pastural drainage, aspiration, etc. All convalescent patients with muscle involvement should have functional training and rehabilitative training. This should be done by a physical therapist in the out-patient department or in the hospital's therapy department.

FLEXION TREATMENT OF LOW BACK PAIN

William L. Waldrop, M.D., and Howard B. Shorbe, M.D., F.A.C.S., Oklahoma City, Okla. In JOURNAL OF THE OKLAHOMA STATE MEDICAL ASSOCIATION, 44:4:138, April 1951.

Treatment of low back pain is a matter of management rather than that of specific treatment. The principle of the treatment by the flexion method is to correct the lordosis and maintain the correction. Its proper use requires diligent cooperation of the patient and also constant attention by the physician. The patient must understand his condition and the treatment: one of the most important parts of the treatment is the teaching of the patient. An articulated skeleton or x-rays are very valuable

(*Continued on page* 78)

The *Gentarth* formula constitutes a new, direct approach for relief of pain and reduction of swelling and joint inflammation in rheumatoid arthritis. *Gentarth* is non-hormonal in action.

Sodium gentisate has been found to produce favorable results in both rheumatoid arthritis and acute rheumatic fever,[2] possibly because of its inhibiting effect on the hyaluronidase in synovial cavities.[3,4] Inclusion of salicylate, as in the *Gentarth* formula, provides additional analgesic action and enhances effectiveness.

Gentarth tablets also contain succinic acid to protect against increase in prothrombin time—a necessary precaution in prolonged salicylate therapy.

Each tablet contains:

Sodium Gentisate	100 mg.
Raysal *(representing 43% Salicylic Acid and 3% Iodine in a Calcium-Sodium Phosphate buffer salt combination)*	325 mg.
Succinic Acid	130 mg.

Dosage: 2 to 4 tablets 3 or 4 times daily (after meals and before bedtime).

Supplied in bottles of 100, 500 and 1,000. Available through all ethical pharmacies.

1. *Boyd, L.J., Lombardi, A.A., and Svigals, C.: New York Med. College Bull., 13:91, 1950.*
2. *Meyer, K. and Ragan, C.: Mod. Concepts of Card. Disp., 17:2, 1948.*
3. *Quick, A.J.: J. Biol. Chem., 101:475, 1933.*
4. *Guerra, J.: J. Pharm. Exper. Ther., 87:1943, 1946.*

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to restore the Arthritic patient to

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"The best results were obtained in patients . . . treated with sodium gentisate and salicylate"[1]

Tablets

GENTARTH

The original preparation containing sodium gentisate, an inhibitor of the spreading factor enzyme, hyaluronidase

for this purpose. The program utilizes various steps which are used or left out as suits the needs of the individual patient. The entire treatment is very natural for the patient. Observation of any audience shows many people flexing the lumbar spine by sitting with legs crossed, their feet up, or their knees resting on the back of the seat in front of them. Brass rails were placed in front of bars to permit flexion of the lumbar spine during prolonged standing.

Rest is the most important of all. Severe cases are placed on complete bed rest in a double Gatch bed with the thighs flexed constantly at 45 degrees and the head of the bed elevated for comfort. The buttocks lay on the incline with the thighs and the lumbar spine at the depth of the "V" made by the bed. Knees may be flexed as comfortable.

Traction is applied by means of a canvas girdle about the sacral and trochanteric regions. Medication is used as necessary.

Some form of heat is used routinely. Massage is of limited early value, but may be more beneficial later.

In some cases a flexion cast is beneficial, but it must be applied correctly and fit well.

A brace is not required commonly.

Exercises are designed to stretch the tight back extensors and hip flexors, and to strengthen the abdominals and gluteals. The latter two groups are the flexors of the pelvis. To strengthen the abdominals the patient lies flat on his back and draws the thighs up on the chest, one at a time and then both together. This also stretches the back muscles. To stretch the hamstrings he uses the same position except that the knee is extended with the leg straight upward. To strengthen the gluteals the patient lies flat on his back with hips and knees flexed, and lifts the hips while holding the lumbar spine down flat.

The most important part of the entire treatment is teaching the patient actively to correct his poor posture and to prevent positions and activities which cause him poor posture. The

(Continued on page 82)



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Soothing the Hemorrhoidal Area... Analgesic, vasoconstrictive medication in contact with the entire hemorrhoidal zone is provided in Numoroidal Suppositories. The special emulsifying base mixes with the secretions to assure coverage of the rectal area.

Convenient: Individually packed. No refrigeration necessary.

Formula: ephedrine hydrochloride 0.22%; benzocaine 5.00%, in a special emulsifying base. Average weight of 1 suppository—1.8 Gm.

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Immediate prolonged control of arterial tension through the intravenous route

The administration of Veriloid Intravenous to the patient in a hypertensive crisis produces—in a matter of minutes—a dramatic drop of arterial tension to normal or near-normal limits. For the first time, the physician now has available a potent hypotensive alkaloidal fraction of Veratrum capable of producing any desired degree of blood pressure reduction, with definite control of the intensity and duration of its action.

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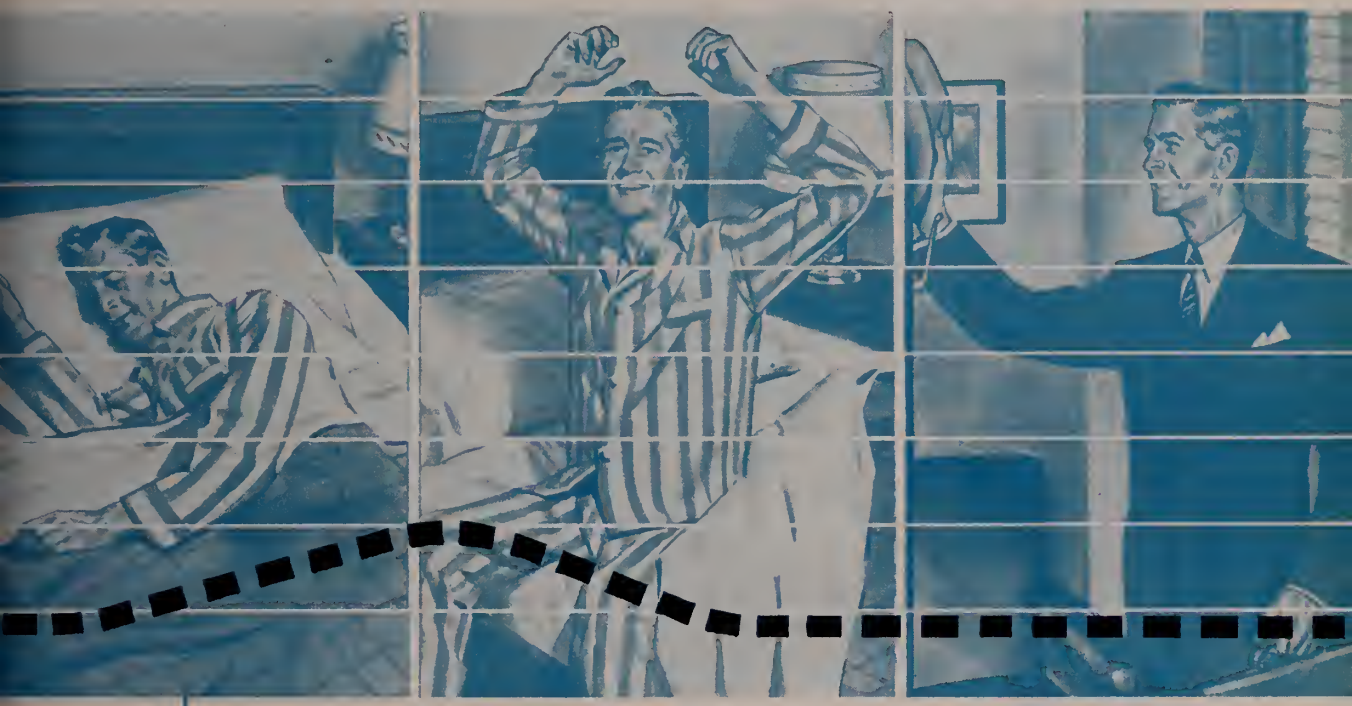
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Physical Medicine (Continued)

basic tenets of the method require the patient to correct his bad postural habits and then to maintain good posture. If he resumes his old lordotic posture, his back pain will return. He is taught to sit with the hips "tucked under" and with the knees higher than the hips, and in driving to keep the seat forward to attain this position. He sleeps on a firm bed, not on his abdomen, but with the knees flexed lying on his side, or if on his back with a pillow under the knees. He is taught never to lift weights above his elbows, and to rest one foot on a stool when standing. He always keeps his low back flat. At home he leans against a wall or door attempting to touch the entire lumbar spine. A very useful home treatment is to have the patient lie on his back with the hips and knees each flexed 90 degrees and the calves in the seat of a chair of suitable height. Much relief is obtained also by pulling the thighs up on the chest with the hands, while lying on the back, thus stretching the painful cramping muscles.

Many years have passed since the conception that lordosis as such represents an unstable mechanical weakness in a spine. The medical progression has been slow to give up the old methods of treating backache in extension. Correction of sway back is mandatory in low back pain. Our experience in the past four years has given convincing evidence that the flexion treatment will relieve a high percentage of low back pain.

Mechanical and antibiotic therapy . . . are not the treatment of pulmonary tuberculosis. Rest is the treatment. Mechanical therapy and the antibiotic drugs supplement rest, but they do not supplant it. Calif. Med., Edward W. Hayes, M.D., December, 1950.

Health is today recognized as more than the absence of disease, and the field of health is not the exclusive concern of any one profession or specialty, whether that be medicine, social work, education, government or diplomacy. Health is an individual and — more importantly in the last half of the twentieth century — a social entity. Custom, usage and necessity have resulted in an undue worldwide preoccupation with disease. Personal health, national health and world health in terms of a balanced global ecology are the great challenge of the second millennium of the Christian Era. Edit., New England J. Med., May 17, 1951.



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BOOK REVIEWS



ROENTGEN MANIFESTATIONS OF PANCREATIC DISEASE, Maxwell Hervert Poppel, M.D., F.A.C.R., Charles C. Thomas, Publisher, Springfield, Illinois. A volume of 389 pages, 12 chapters, a complete reference and index. It is liberally illustrated.

The anatomy of the pancreas and the duodenum with most important variants is presented with their relationship to other surrounding structures.

Methods of x-ray examination for the pancreas are well presented with limitations of these examinations given as well as their specific values. X-ray anatomy is discussed and compared to dissecting room anatomy with subsequent anatomical alteration from an x-ray standpoint given according to specific diseases.

Complete pathologic discussion is presented of all inclusive diseases of the pancreas with effect on and extension to surrounding structures. A most interesting and complete differential diagnosis is included with the negative findings discussed as well as the positive variety.

The work closes with presentation of recent statistics pertinent to disease of the pancreas of considerable importance.

From the title of this work one might get the impression that it was written for radiologists. However its vast scope makes it a valuable reference for any one in the medical field who encounters any form of pancreatic disease.

J. H. G.

AN ATLAS OF ANATOMY by J. C. Boileau Grant, M.C., M.B., Ch.B., F.R.C.S. (Edin) Professor of Anatomy, University of Toronto — Third Edition — Cloth $12.00. The Williams & Wilkins Company, Baltimore, 1951.

This book is now being presented as the third edition. The first edition was reprinted twice as was likewise the second edition. The popularity of this work is thus actually proven.

In this edition more than 70 of the illustrations are new and 28 of the old illustrations have been either improved or replaced and to some color has been added.

The printing is of good size and the format of the book makes it easily referred to for any item.

The diagrammatic illustrations of Dr. Grant's work continue as previously to be a source of great satisfaction. This is an Atlas of Anatomy of value for the student or for the practicing physician — allowing plenty of material for definite study of detail; or for a quick refresher as to structure, relationship and relative positions.

An anatomy to adorn the facilities of any library.

C. P. B.

ANATOMY IN SURGERY — Philip Thorek, M. D., F.A.C.S., F.I.C.S. Assistant Clinical Professor of Surgery, University of Illinois College of Medicine, Chicago. Foreword by Warren Cole, M.D. — First Edition, 1951. Cloth $22.50. J. B. Lippincott Company, Philadelphia, London, Montreal.

The author in this work has presented quite an innovation. The whole of anatomy is covered from the surgical view point, and yet the clearness of the presentation in text and illustration makes it a very scientific anatomy as such. Surgical technic of important operations is presented, concurrently with the anatomy.

The style is clear and refreshing. The text is "easy reading", the illustrations are clear, accurate and it is a relief to note the large size of lettering for the labels; this feature makes it easy to find and identify the various details of a "drawing". The illustrations

(*Continued on page* 88)

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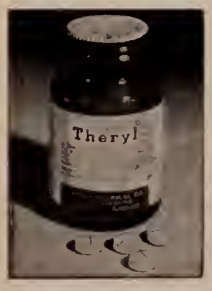
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1. Hoffman, Murray M., Ill. Dent. Jl., 19:439 445 (Oct., 1950)

2. McNealy, Raymond W., Ill. Med. Jl., 97:150 (Mar., 1950)

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BOOK REVIEWS (Continued)

are done by one artist, working evidently in close cooperation with the author himself. There are many cuts of cross sections presented in a most effective manner to show point of section and relative positions, adding greatly to detail.

The author is to be congratulated for this work. All surgeons will find it quite an addition to their armamentarium. Its presentation of the subject from the view of literary technique is of no small caliber.

For conciseness the work is adequate. For accuracy the book is complete. For correlation and integration of surgery and anatomy the book is unusual.

This volume as prepared is a work that adds greatly to one's conception of anatomical facts and enables quick resumé of any point in question.

C. P. B.

SCOLIOSIS PATHOLOGY, ETIOLOGY AND TREATMENT: By Samuel Kleinberg, M.D. Attending Orthopaedic Surgeon, Hospital for Joint Diseases: Consulting Orthopaedic Surgeon, Lebanon Hospital, Maimonides Hospital, Hospital for Special Surgery, New York City; Lecturer in Orthopaedics, New York University Medical School; Member American Orthopaedic Association; Member American Academy of Orthopaedic Surgery; Fellow, American College of Surgeons; Fellow, New York Academy of Medicine; Member, American Academy of Compensation Medicine. Baltimore, THE WILLIAMS & WILKINS COMPANY 1951. Price $7.50.

This is a most comprehensive monograph on scoliosis and has been completely revised by Dr. Kleinberg since his original works was published nearly 25 years ago.

It is conveniently divided into two parts. Part I covers anatomy, embryology, physiology, pathology and etiology. Part II covers all phases of treatment: namely preventative and corrective, gymnastic and surgical.

The illustrations have been selected with care and are very informative. The arrangement is logical and concisely enumerative, as for example he lists 7 causes for functional scoliosis and 12 known origins of structural scoliosis, plus many cases of unknown origin. The exercises Dr. Kleinberg has found most useful thru the years, are presented, and he fully describes 37 developmental or symmetric and 15 corrective or asymetric exercises.

J. W. P.

THE DIAGNOSIS AND TREATMENT OF ADRENAL INSUFFICIENY, by George W. Thorn, M.D., Hersey Professor of the Theory and Practice of Physic. Harvard Medical School, and Physician-in-Chief, Peter Bent Brigham Hospital, Boston, with the collaboration of Peter H. Forsham, M.D., M.A. (Cantab.), Instructor in Medicine, Harvard Medical School, and Junior Associate in Medicine, Peter Bent Brigham Hospital, and Kendall Emerson, Jr.,

(*Continued on page* 90)



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1. Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.
2. Berberian, D. A., Dennis, E. W., and Pipkin, C. A.: *Am. Jour. Trop. Med.*, 30:613, Sept., 1950.

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BOOK REVIEWS (Continued)

M.D., Assistant Professor, Harvard Medical School and Senior Associate in Medicine, Peter Bent Brigham Hospital. Second edition. Cloth. $5.50. Pp. 180, with 25 tables and 32 figures (2 in full color). Charles C. Thomas, Publisher, Springfield, Illinois, 1951.

The excellence and deserved popularity of this book is indicated by the fact that this is the second edition. The first came out in 1949. It is divided into 17 chapters as follows: I. Introduction, II. Physiological Considerations, III. Chemical Consideration, IV. Types of Adrenal Cortical Insufficiency, V. Signs and Symptoms of Addison's Disease, VI, Laboratory Findings in Addison's Disease, VII. Screening and Tolerance Tests in Adrenal Cortical Insufficiency, VIII. Outline of Diagnostic Program, IX. Differential Diagnosis of Adrenal Cortical Insufficiency, X. Adrenal Cortical Hormone Preparations, XI. Treatment of Adrenal Crisis, XII. Treatment of Chronic Adrenal Cortical Insufficiency, XIII. Treatment of Patients with Addison's Disease Undergoing Surgery, XIV. Toxic or Undesirable Reactions Encountered in the Use of Adrenal Hormone Preparations, XV. Clinical Experience in the Use of Synthetic Cortisone Acetate (11-dehydro-17-hydroxycorticosterone, XVI. Prognosis, XVII. Conclusion, and a Bibliography.)

Our increasing knowledge of adrenal functions makes it imperative that surgeons and internists as well as endocrinologists familiarize themselves with this field. Laboratory procedures now generally available enable us to asses with some degree of assurance the level of adrenal function. Curiously, the advances which enable us to do these things only confirm what the older endocrinologists (SaJous, Sergent, et al) suspected.

This would be a valuable addition to any physician's library.

J. H. H.

Obstetrical Practice. Edited by Alfred C. Beck, M.D. — Professor Emeritus of Obstetrics and Gynecology, State University of New York, College of Medicine at New York City; Formerly Professor of Obstetrics and Gynecology, Long Island College of Medicine; Formerly Obstetrician and Gynecologist-in-Chief, Long Island College Hospital; Consultant in Obstetrics and Gynecology, Long Island College Hospital, and Norwegian Hospital, Brooklyn, N.Y., U. S. Haval Hospital, St. Albans, N.Y., Vassar Brothers Hospital and St. Francis Hospital, Poughkeepsie, N.Y. Fifth Edition. Baltimore: THE WILLIAMS & WILKINS COMPANY, 1951. Price $10.00.

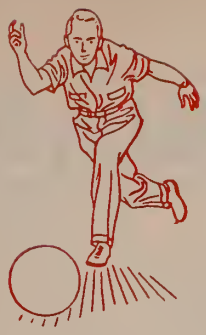
This is the 5th Edition of an old standard Obstetrical Textbook. It has been extensively revised and rewritten. This edition contains 106 new illustrations and an appendix of 22 reproductions and X-rays; 309 of the old illustrations have been redrawn.

The book is well written and organized; the subject

(*Continued on page 92*)







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BOOK REVIEWS (Continued)

matter clearly and logically presented.

The chapters on Posterior Positions or the Occiput, Face Presentation, Breech Presentation, Tranverse Presentation and Compound Presentation are masterpieces of clarity and conciseness, the pictorial and outline summary which concludes the discussion on each type of presentation is extremely valuable.

J. W. P.

ORTHOPAEDIC SURGERY. By Walter Mercer: M.B., Ch.B., F.R.C.S. (Edin), F.R.S. (Edin). Professor of Orthopaedic Surgery, University of Edinburgh; Director of Orthopaedic Services to the South-Eastern Regional Hospital Board, Scotland. With a Foreword by Sir John Fraser, Bart., K.C.V.O., M.C., F.R.S. Ed., F.R.C.S. Ed., M.D., Ch.M., F.R.A.C.S., F.A.C.S. Regius Professor of Clinical Surgery in the University of Edinburgh. Fourth Edition. Baltimore: THE WILLIAMS & WILKINS COMPANY, 1950. Price $10.00.

This book can be classified as another text on orthopaedics. It contains none of the brilliance which characterizes the writings of Watson-Jones. It is the painstaking efforts of a British general surgeon gleaned from a series of lectures and clinics on orthopaedic subjects to British medical students.

J. W. P.

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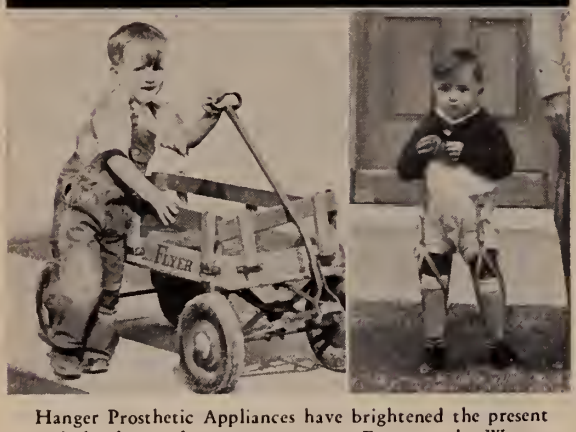
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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

AN ATLAS OF NORMAL RADIOGRAPHIC ANATOMY: By Isadore Meschan, M. A., M. D., Professor and Head of the Department of Radiology, University of Arkansas School of Medicine. With the assistance of R. M. F. Farrer-Meschan, M. B., B. S., (Melbourne, Australia). 593 pages, 1044 illustrations on 362 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price $15.00.

PSYCHOSOMATIC GYNECOLOGY: Including Problems of Obstetrical Care: By William S. Kroger, M. D., Assistant Clinical Professor of Obstetrics and Gynecology, Chicago Medical School; and S. Charles Freed, M. D., Adjunct in Medicine, Mount Zion Hospital, San Francisco, California. 503 pages. Philadelphia and London: W. B. Saunders Company, 1951. Price $8.00.

AUTOPSY DIAGNOSIS AND TECHNIC: By Otto Saphir, M. D., Pathologist, Michael Reese Hospital; Clinical Professor of Pathology, University of Illinois Med-

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RADIOACTIVE IODINE IN THE DIAGNOSIS AND TREATMENT OF DISEASES OF THE THYROID

ical School, Chicago. Foreword by Ludvig Hektoen, M. D., Third Edition, Revised and Enlarged. Illustrated. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers. $6.00.

Peptic Ulcer — Clinical Aspects — Diagnosis — Management: Editor, David J. Sandweiss, M. D., F. A. C. P., Associate Attending Physician, Division of Internal Medicine, Harper Hospital, Detroit, Michigan. Editorial Committee, A. H. Aaron, Henry L. Bockus, George E. Daniels, George B. Eusterman, L. Kraeer Ferguson, A. C. Ivy, Sara M. Jordan, Frank H. Lahey, Walter L. Palmer, Harry Shay, Albert M. Snell, Dwight L. Wilbur. 790 pages with 164 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price $15.00.

Arthritis and The Rheumatic Diseases. By Philip Lewin, F. A. C. S., F. I. C. S. Professor and Chairman of the Department of Bone and Joint Surgery, Northwestern University Medical School; Professor of Orthopedic Surgery, Cook County Graduate School of Medicine; Senior Attending Orthopedic Surgeon and Chairman of Department, Michael Reese Hospital; Attending Orthopedic Surgeon, Cook County Hospital, Chicago. Foreword by Morris Fishbein, M. D. New York, Toronto, London, McGraw-Hill Book Company, Inc. $3.50.

Thyroid Function and Its Possible Role in Vascular Degeneration. By William B. Kountz, M. D. Assistant Professor of Clinical Medicine, Washington

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University School of Medicine, Director of Clinical Services, Division of Gerontology, Washington University School of Medicine and the St. Louis City Infirmary Hospital. Consulting Physician, Barnes Hospital and Lutheran Hospital, St. Louis, Missouri. Charles C. Thomas, Publisher, Springfield, Illinois. $2.25.

STATISTICS FOR MEDICAL STUDENTS AND INVESTIGATORS IN THE CLINICAL AND BIOLOGICAL SCIENCES. By Frederick J. Moore, M. D., Associate Professor of Experimental Medicine, Frank B. Cramer, B. A., Research Fellow, and Robert G. Knowles, M. S., Research Associate, Department of Experimental Medicine, University of Southern California School of Medicine. 11 figures; 16 tables; 113 pages; September 19, 1951. $3.25.

BODY MIND AND SUGAR. By E. M. Abrahamson, M. D., and A. W. Pezet. New York: Henry Holt and Company. $2.95.

711 MEDICAL MAXIMS. By William S. Reveno, M. D., Assistant Professor of Clinical Medicine, Wayne University Medical College, Attending Physician, Harper Hospital, Consulting Physician, Detroit Receiving and Highland Park General Hospitals, Detroit, Michigan. With forewords by Frederick A. Coller, M. D., and William J. Kerr, M. D., Charles C. Thomas, Publisher, Springfield, Illinois. $3.75.

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ROENTGEN ANATOMY. By David Steel, M. D., St. John's Hospital and Evangelical Deaconess Hospital, Cleveland, Ohio. Charles C. Thomas, Publisher, Springfield, Illinois.

A BIBLIOGRAPHY OF INFANTILE PARALYSIS. 1789-1949. With selected abstracts and annotations. Prepared under direction of The National Foundation for Infantile Paralysis, Inc. Edited by Morris Fishbein, M. D., Editor, Excerpta Medica, and Ella M. Salmonsen, Chief, Medical Department, John Crerar Library, Chicago, with Ludvig Hektoen, M. D. Editor Emeritus, Archives of Pathology. Second Edition. Philadelphia, London, Montreal, J. B. Lippincott Company.

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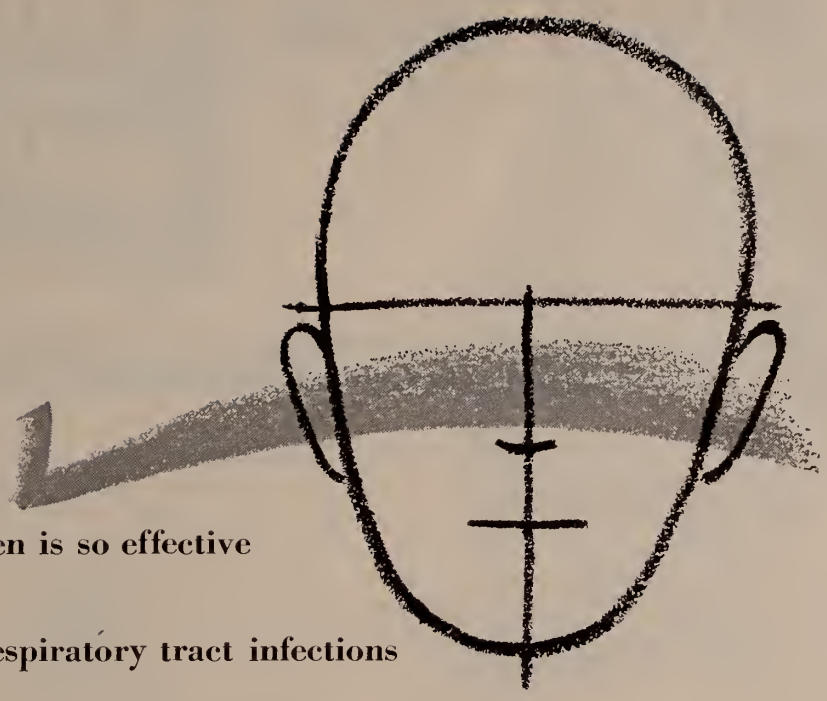
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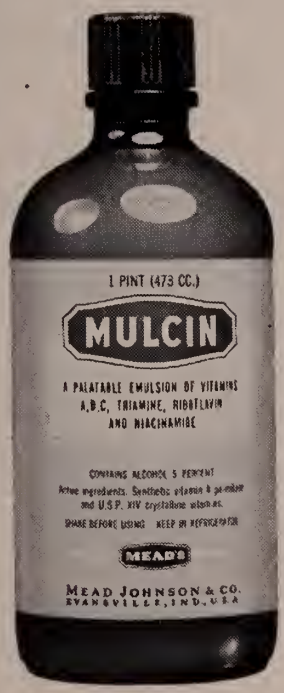
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VOL. 100 ✳ NO. 6

December, 1951

The Management of Deafness

✦

Complications of Puerperium

✦

The Practicing Physician and Public Health

✦

Gastro-Intestinal Distention

✦

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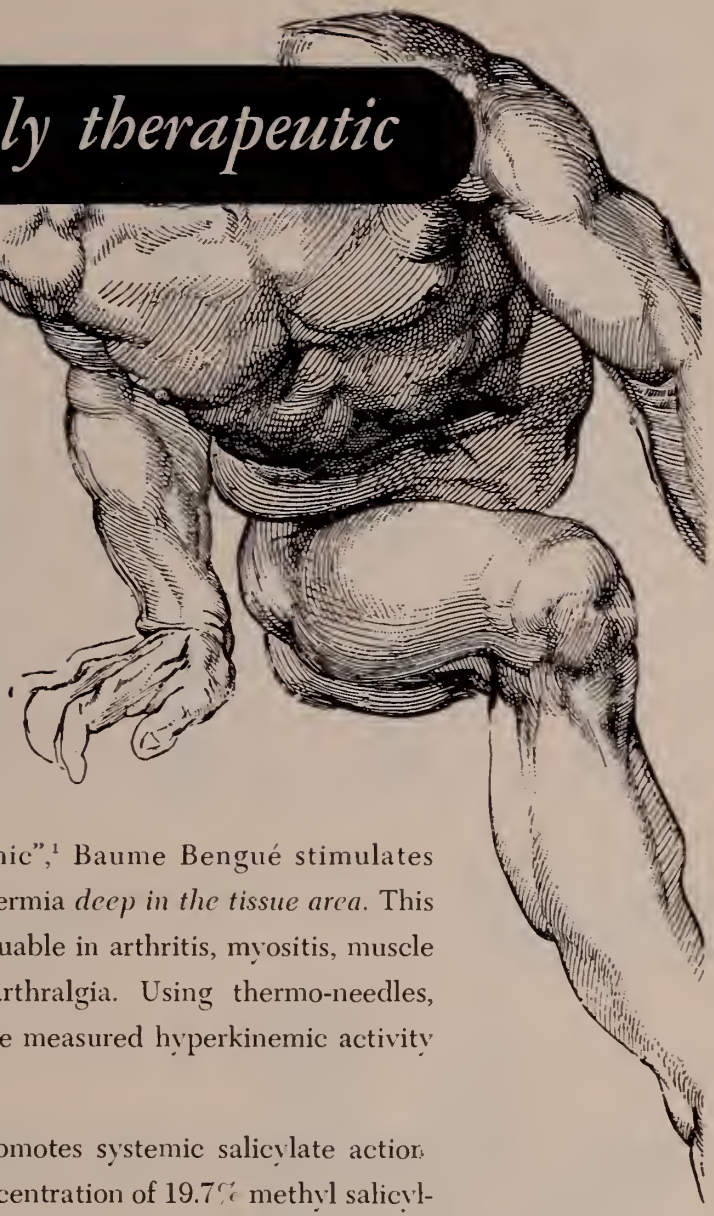
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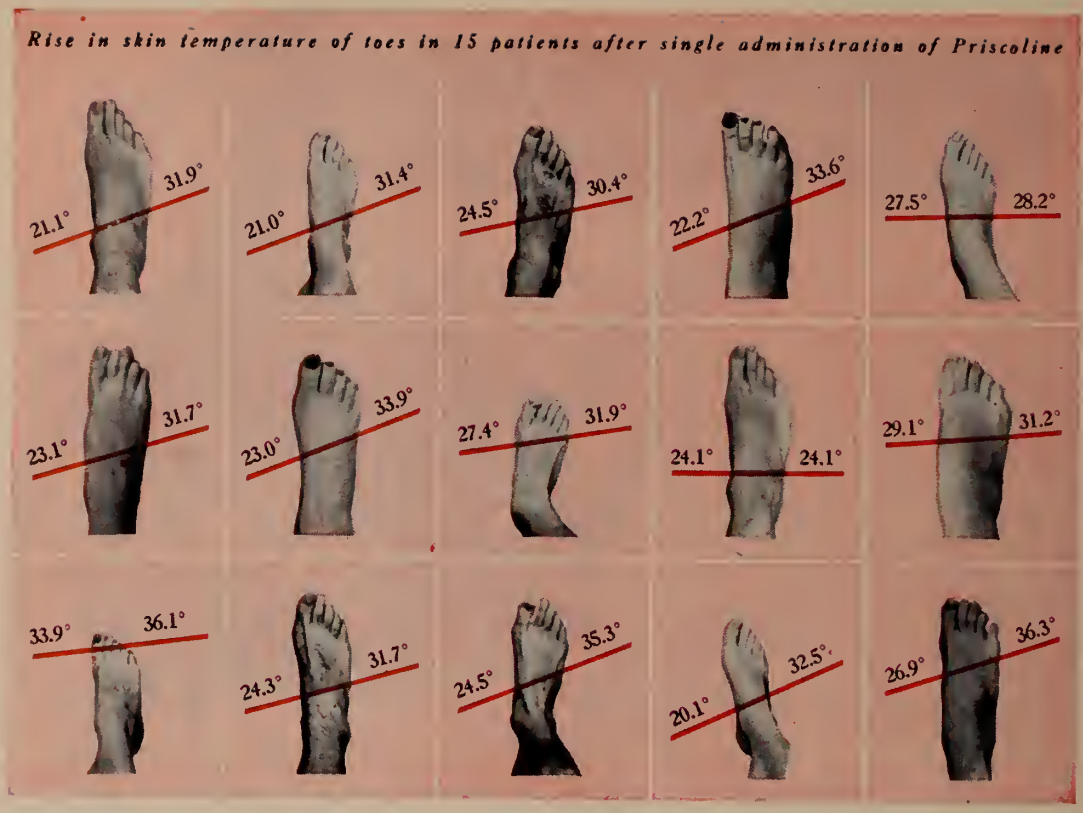
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1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

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1. Ready, W. J.: J. of Lab. & Clin. Med. 37:365 (March) 1951.

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1. *Boyd, L.J., Lombardi, A.A., and Svigals, C.: New York Med. College Bull.*, 13:91, 1950.
2. *Meyer, K. and Ragan, C.: Mod. Concepts of Card. Disp.*, 17:2, 1948.
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4. *Guerra, J.: J. Pharm. Exper. Ther.*, 87:1943, 1946.

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1. Meyer, K. Am.J.Med. 5:482,1948.
2. Wang, K.J. and Grossman, M.I. Am.J.Phys. 155:476,1948.
3. Grace, W.J. Am.J.Med.Sc. 217:241,1949.
4. Hufford, A.R. Rev. of Gastroenterology. Aug.,1951.

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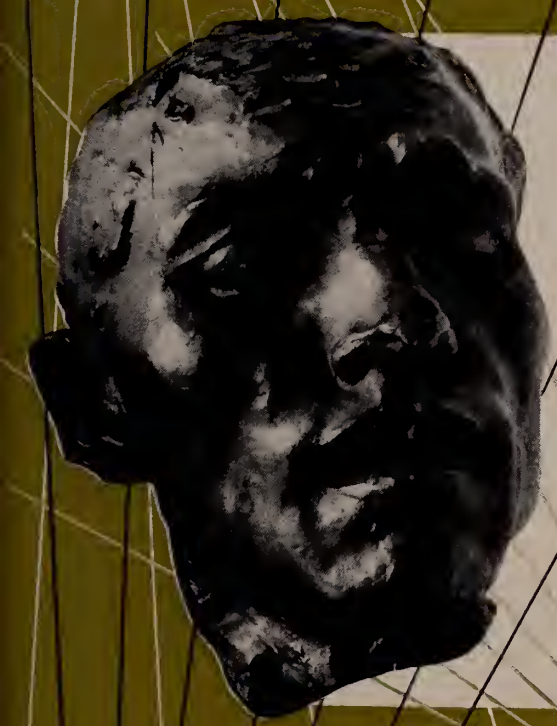
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"...relief from the symptoms..."[1] of PREMENSTRUAL TENSION



Abstract

Vainder[1] administered M-Minus 4 in 153 cases of premenstrual tension. All patients had most or all of the symptoms, which include tissue turgor, abdominal distention, headache, backache, nausea, breast tenderness and fullness, irritability and nervousness. The patients did not know the purpose of the medication.

M-Minus 4 was taken in tablet form, three times daily, beginning about four days before menstruation. "Results were uniformly good" with "at least some relief from the symptoms of distention, breast tenderness and abdominal discomfort" in every case. Of 41 patients with concomitant dysmenorrhea, 32 were completely relieved.

1. Vainder, M.: Theory and Rationale in the Treatment of Premenstrual Tension and Dysmenorrhea, Industrial M. & Surg. *20*:199-201 (April) 1951.

Each tablet contains:

N,N-Dimethyl-N'- (2-pyridyl) -N'-
(p-methoxybenzyl) ethylenediamine
8-bromotheophyllinate [pyrabrom] 50 mg.
Acetophenetidin 100 mg.

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Bottles of 24 and 100 tablets

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Abstract

Bickers and Woods[2] define premenstrual tension as essentially a water toxemia caused by endocrine disturbance. They studied a group of 22 patients with severe premenstrual tension. The average weight gain due to premenstrual water retention was 6.8 pounds (in one patient 11.5 pounds). Symptoms did not occur when the water-fixing substance of the premenstrual period was blocked.

The effective agent was the antipitressin compound, pyrilamine bromotheophyllinate. In an experimental study the same authors induced edema in rats by administration of pitressin; this was not improved by testosterone or ammonium chloride, but was relieved by the antipitressin diuretic agent.

M-Minus 4 combines the antipitressin diuretic agent, pyrilamine bromotheophyllinate, with acetophenetidin, well known for its profound analgesic effect on painful headaches and cramps.

2. Bickers, W., and Woods, M.: Premenstrual Tension—Rational Treatment. in press.



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★ ★ ★

Patient: T.H. (shown in photos on opposite page), age 62, widowed, father of 6 children, afflicted with arteriosclerotic, hypertensive, cardio-renal disease. Although basically a fine individual, he had become a "typical alcoholic".

"His emotional balance became seriously disturbed and he would cry and exhibit depressive characteristics, with or without intoxication ... His mood would rest on a hair ... His nausea, vomiting and inebriety; his emotional outbursts, depression and constant reiteration; his carelessness of personal habit; ... all of these had gradually decreased the love of his children for him."

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ameliorates mood...relieves inner tension

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These unposed photographs of patient T. H. were snapped during an actual interview with his physician. He is describing his symptoms of mental and emotional distress. See the opposite page for the case history of this patient.





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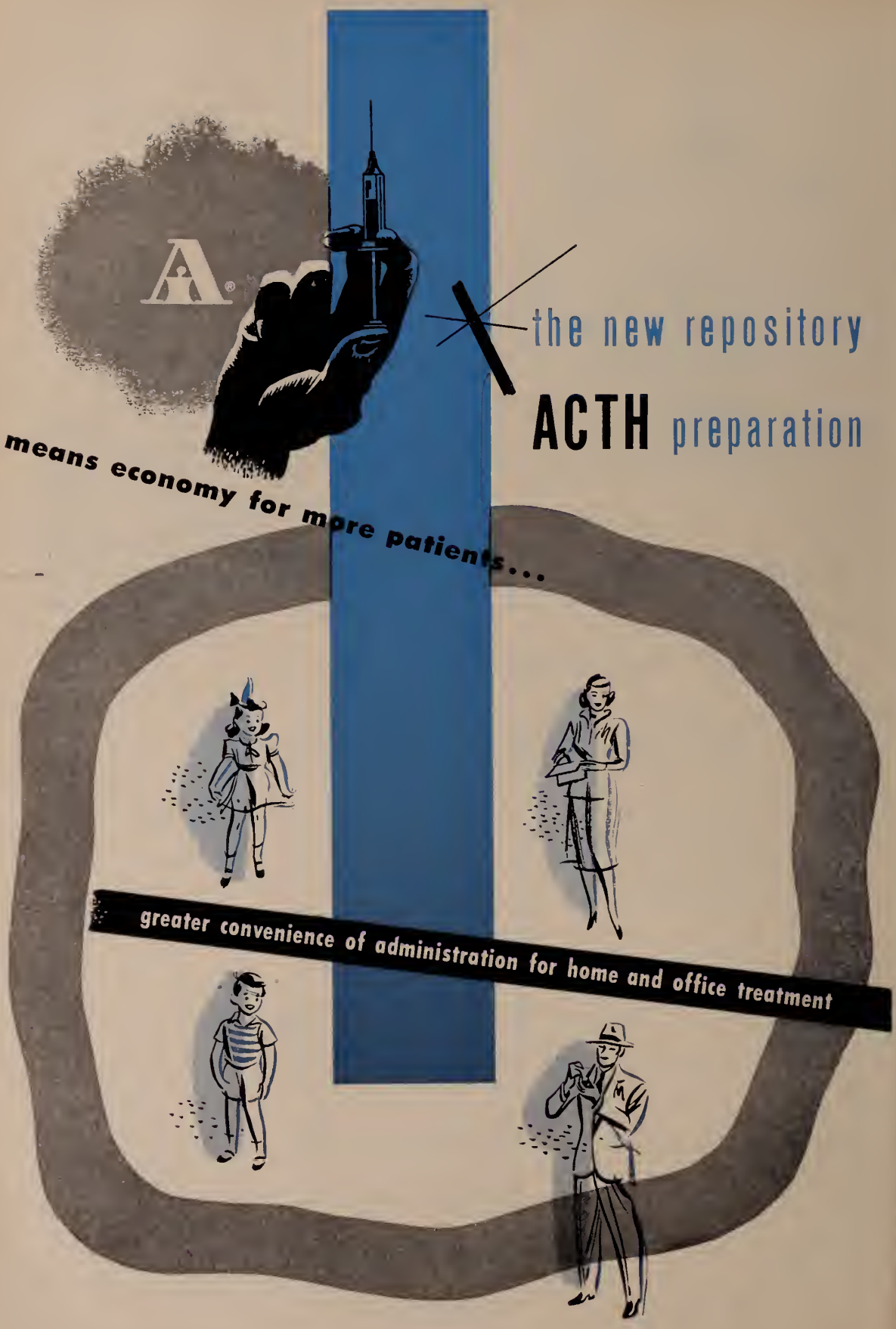
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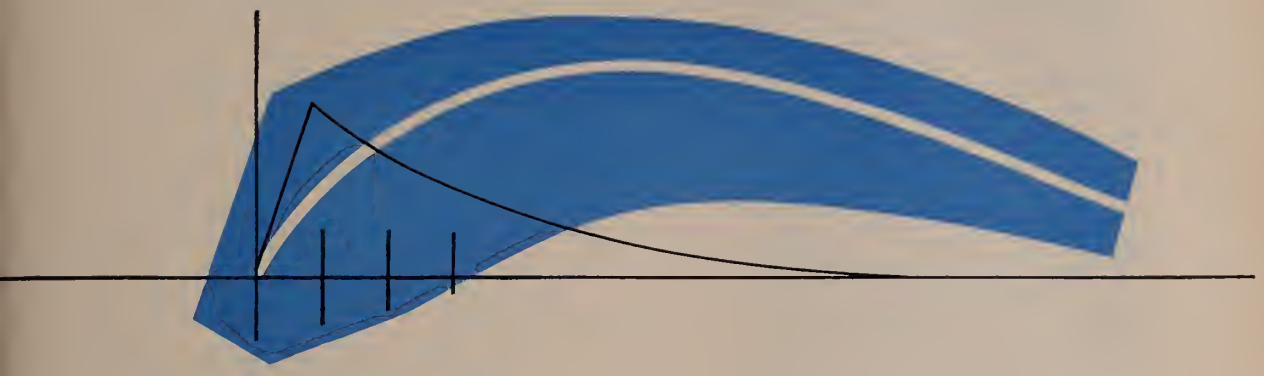
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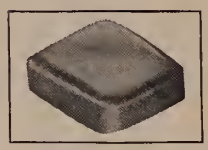
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1. Eagle, H., and Fleischman, R.: Proc. Soc. Exper. Biol. & Med. *68*:415, 1948

2. Bachman, M.C.: J. Clin. Invest. *28*:864, 1949

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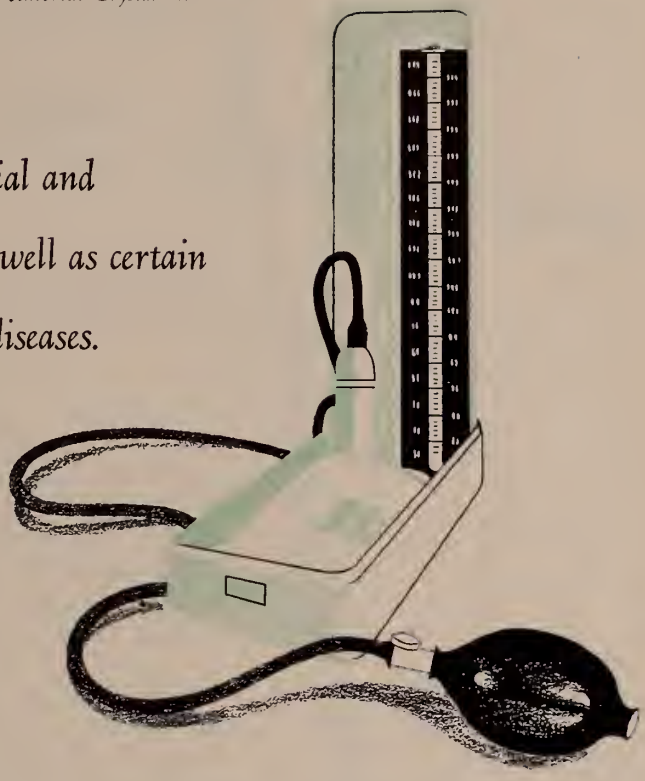
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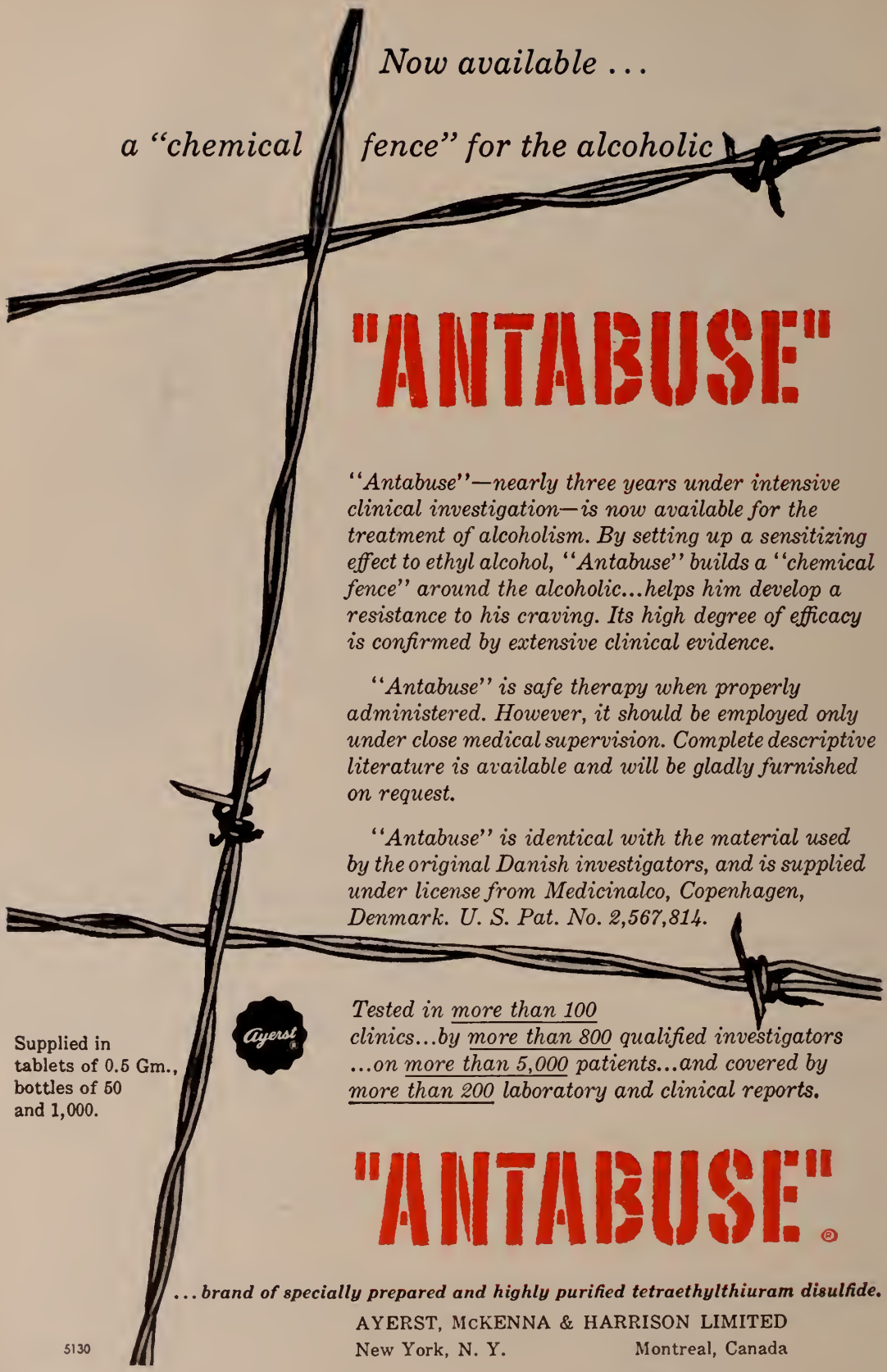
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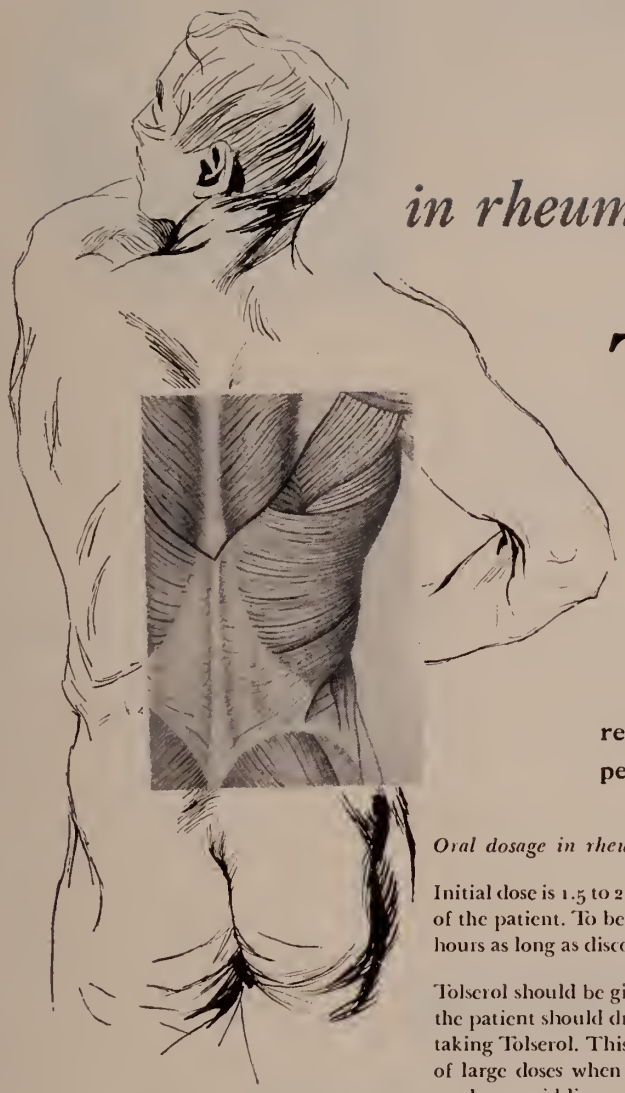
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Initial dose is 1.5 to 2.0 Gm. or more, depending on the weight of the patient. To be followed by 0.5 to 0.75 Gm. every three hours as long as discomfort continues.

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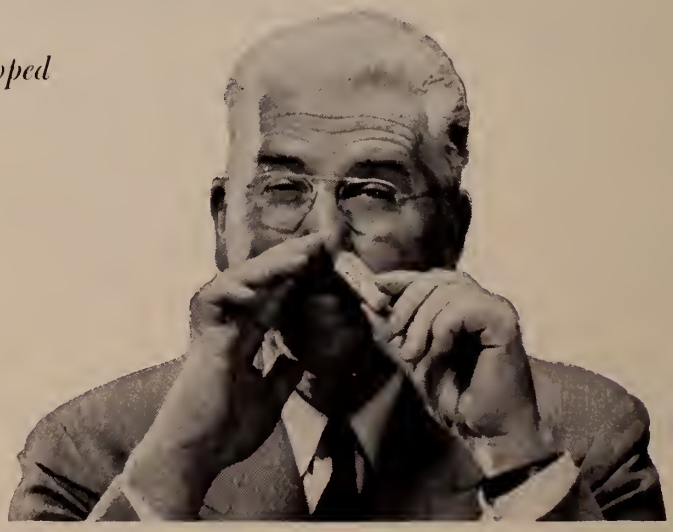
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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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Vol. 100, No. 6 December, 1951

THE MATCHING PLAN AND INTERNSHIPS

At this time each year approximately 800 hospitals offer nearly 10,000 approved internships to about 6,000 senior medical students. Obviously the situation is troublesome because there are more internships available than there are students to fill the positions. In the past the hospitals and the students went their own way so that the business of acquiring interns was "catch as catch can." But the method was not satisfactory. The schools blamed the hospitals for coercing medical students to signing up long before they knew what they were doing and the hospitals retaliated by maintaining that the schools were influencing their students to avoid smaller hospitals and to go to the larger medical centers.

Several years ago a plan was formulated to bring the hospitals and the schools closer together. It was agreed that all the applications were to be sent simultaneously to hospital and telegrams of acceptances were to be sent back to the students on pre-arranged dates. The plan represented an improvement but was not satisfactory. There was a last minute scramble which was distasteful not only to the student but also to the hospital. The hospitals, for example, sent out acceptances and then had to wait for the medical student to accept or reject the appointment. During the delay they lost many candidates while waiting for the young man or woman to make up his mind. Meanwhile the student was considering the four or five offers for internship he received. Many withheld their decision until they had heard pro or con from the hospital that they wanted but where the chances of appointment were questionable (flyers). At any rate, the plan was not ideal; in fact it was so chaotic that the members of the Association of the American Medical Colleges decided that another change was necessary. The outcome was the new matching plan that goes into effect this year. The credit goes to Dr. F. J. Mullin, Dean of the Chicago Medical School, and to Dr. John M. Stalnaker, the Director of Operations for the Committee. It has the approval of the American Hospital Association, the American Protestant Hospital Association, Association of Medical Colleges, Catholic Hospital Association, the Council on Medical Education and Hospitals of the American Medical Association and the medical services of all the federal agencies offering internships. The new plan should benefit both the hospitals and the applicants, but will not influence the number of internships filled nor will it bring about any wider distribution of the available interns. Under this system, hospitals deemed desirable by the students will be filled and those deemed less desirable will be left without interns. Since there are more internships being offered than

there are available applicants, it is obvious that no system ean satisfy all hospitals. The new plan does, however, insure a fair prineiple of distribution so that eaeh hospital will be more likely to secure the interns it considers most desirable and each medical student will more likely reeeive the best appointment open to him in aceordance with his expressed preferenee. The student may still visit the hospital to which he wishes to apply, talking to offieials and others there. He makes an individual applieation and may apply to as many hospitals as he is interested in and will submit application papers aeeording to the hospital regulations. The hospital, meanwhile, is free to contact any eligible student and to request personal interviews or other procedures they deem desirable. Under this system, complete freedom of applying any eriteria for selection is fully preserved for both the student and the hospital. But the sueeess of the plan will depend upon eooperation and good faith on the part of every one is neeessary. It will require universal student and hospital support.

In this proeedure the internship appointments are made by matehing the preference of the student for a hospital with the preferenee of the hospital for the student. The student will submit to the National Interassociation Committee a rank order list of his preferenee for the hospitals to whieh he has applied and the hospitals will follow suit by rating the students who have applied to it, ranking in order the applieants in eaeh of its groups. The first group is rated as "1" and is used to indicate the students most preferred by the hospital. The rating "2" will be used for the applicants judged by the hospital to be next desirable. This is followed by ratings 3, 4, etc.

The matehing is done in a series of steps called "runs." In the first run, the students who rank the hospital as first ehoice are matehed with the hospital that has rated them as number 1. It is believed that this group will aecount for almost one-half of all the students registered in the plan. These student names are removed from the list of other hospitals lower on their list to which they have applied, and the remaining names on the hospital list are then advaneed in order and the top ones are tentatively placed in the aceepted group to fill the vacaneies. In this way a man cannot be passed by a person below him on a hospital preferenee list. He advances on that list only as a man ahead of him is removed beeause of having been plaeed in a hospital higher on that student's preference list. In the end the man or woman interns at the hospital highest on his preference list whieh offers him a place.

The matching plan is not new. It is in operation in some sehools to faeilitate sorority rushing. It requires the use of an IBM maehine, a qualified accountant and technieians. In a trial run last year involving 500 students, 86 per eent were matehed with hospitals of their first or second choiee. Hospitals were matehed with 91 per eent of the students they chose as the most desirable.

PHYSIOGRAPHY AND DISEASE IN ILLINOIS

David J. Davis, M.D.
Medical State Historian of Illinois

Illinois has been called the Hub of the United States. (Governor Horner called it the Hub of North America.) Situated in the heart of the great Mississippi Valley, it is shaped somewhat like a wedge with bulging sides and a flat top. Water, chiefly as rivers, largely encircles it. Its area is 56.665 square miles. It lies between north latitude 47° and 42°.30′ and in longitude between 87°.35′ and 91°.31′, and has an annual rainfall of approximately 35 inches. The summers are hot and the winters are cold. The cyelonie disturbanees are such as to predispose to frequent tornadoes in the spring, but with fairly uniform weather conditions otherwise.

Today, it is a rich prosperous region, where eorn, soybeans, grains, fruit trees, eattle, hogs, clovers and grasses, trees and shrubs luxuriate, and where mosquitoes, flies, tieks and many other insects thrive. Beneath its fertile soil prodigious amounts of coal, oil, lime rock, and many valuable minerals, too numerous to mention here, oceur.

There resides at present a population of mixed raeial origins numbering over 8 million. Of this number about 5% are Negroes. The number of Ameriean Indians is insignificant. The people on the whole are healthful and increasingly so. In 1948 the erude over all death rate was 10.4. (May be brought up to 1950)

The second largest city in the United States (Chicago) is located near the northeast corner

of the state on Lake Michigan. Several other cities of moderate size are more or less uniformly distributed. At present the rural and urban health problems do not present serious difficulties. This was not always true. A half century ago in order to control such problems it was necessary to resort to the most monumental sanitary engineering enterprise ever undertaken. This was no less a project than to construct a huge canal diverting the waters from Lake Michigan of the St. Lawrence River system across the divide and into the Mississippi River system at a cost of hundreds of millions of dollars. It was a success and saved the lives of millions of people. It continues to do so today.

Associated in many complex ways with these 8 million people are diseases of diverse kinds. In addition to the degenerative and ageing diseases common to all forms of life are large numbers of predator diseases. These predators include viruses, bacteria, animal parasites, fungi, worms, poisonous animals and plants and many of the larger mammalia. Historically man himself has been man's most deadly predator.

Babies are now born almost in a sterile state free from predator organisms. In a few hours after birth organisms, both harmless and harmful, attack them from both without and within. During the remainder of their lives this conflict continues between the predators and the external and internal defensive mechanisms of organisms of which there are many.

The people of Illinois together with their predators are not ancient geologically. Whence came the peoples and their predators? And how? From the present, if we attempt to trace backward this intriguing story, we observe interesting landmarks along the way. Fifty years ago we in Illinois were just at the beginning of modern sanitation, with mortality and morbidity curves responding accordingly.

During the past century, the eighteen hundreds, many of the predators had reached their all time maximum. In the decades of about that time occurred the malaria years. 1832 became and still is known as the cholera year.

Backward we may then proceed to observe the impact of one race upon another, the whites upon the Indians in Illinois. Then back to the eastern shores of America there meeting the early French and English with their diseases and carriers of diseases. Thence back to Europe, Africa and Asia during the seventeenth and eighteenth centuries, at a time when deadly plagues and pestilences prevailed in those continents.

Thence to the agricultural and pastoral stages of civilization when animals and man intermingled freely and transmitting their diseases just as freely.

Beyond these stages are the long ages reaching back to the dawn of the human species; then to the age of the Primates, then to the still earlier fossil animals and plants and finally to the far distant age when only fungi, bacteria, and viruses competed with each other as predators for existence.

It is a very long story, but even so one continuous thread of life runs from the beginning down to the present State of Illinois. This thread though long and devious, might have found as far worse terminal than the Illini Country.

D.J.D.

ILLINOIS PHYSICIANS IN BATTLEFIELD MEDICAL SOCIETY

Two Chicago physicians are members of one of the world's unique medical organizations—The 38th Parallel Medical Society of Korea—the first such association ever formed on battlefield. The story pertaining to the organization of this unique medical society was mailed from Korea, October 24, 1951.

Captain Louis J. Gazzolo, whose residence is 6900 South Shore Drive and Captain Edward Zucker, 4401 West End Avenue, Chicago, both of the 1st Division, meet regularly with Army doctors from 11 nations to discuss techniques for treating battlefield wounds.

The meetings which are held north of the parallel, permit standardization and coordination of methods. Techniques found to be superior by one hospital installation therefore can be in use all over Korea within a matter of days.

Among the charter members are physicians from Corps 1, the 1st Cavalry Division, the 2nd, 3rd and 25th Infantry Divisions, the British Commonwealth Division, the 9th ROK Division and the Swedish and Norwegian mobile surgical hospitals.

Physicians from America, Greece, South Korea, Thailand, The Philippines, Australia,

Canada, Britain, Norway, Sweden and Belgium are united in their determination to provide absolutely the best of medical care to United Nations troops fighting in Korea.

It has been frequently stated in recent years, that there are too many medical societies, but it seems quite obvious that no one could object to the formation of the 38th Parallel Medical Society.

POLIOMYELITIS IN ILLINOIS

The upward surge of Polio incidence during the last four years has far outdistanced funds available for patient care, professional education and research. Year after year, "March of Dimes" contributions have moved steadily ahead, but the March of Polio has continued to out pace the "March of Dimes".

Incidence has tripled during the last four years with the result that the National Foundation is annually faced with an average of thirty thousand cases in contrast to the ten to twelve thousand cases a year formerly considered "normal".

1951 will mark the fourth year in succession in which the National Foundation has gone into debt providing patient care to the unfortunate children and adults who have fallen victim to poliomyelitis. The 1951 deficit is estimated at $5,000,000.00. This means the 1952 "March of Dimes" will be mortgaged for this amount before a cent is set aside for research or for the contingence that lie ahead next summer.

The 1950 case load in Illinois was 1916 cases and the amount spent for patient care only, amounted to $1,361,934.50. Up to October 20, 1,488 cases have been reported.

Never in the history of medicine has such an all out effort been concentrated on conquering one disease. Definite progress has been made in treatment and rehabilitation. Our knowledge of the disease is much greater and methods of control appear within our reach. However, new problems are always arising and the ultimate goal will require years of untiring effort.

The National Foundation supported by the "March of Dimes" has always enlisted the cooperation of the Medical profession and been guided by their suggestions. Much of the success has been due to this association. It is the sincere hope that this close relationship continues and the accomplishments continue to merit the sanction of the Medical profession.

John F. Carey, M.D.

CANCER MORTALITY

During World War II, in all the theatres of the war, the United States had about 300,000 of its armed forces killed. Well may you ask what has World War II to do with carcinoma of the stomach? The number of men killed in this war was mentioned to bring to your attention the fact that in this same period of time, namely five years, carcinoma of the entire digestive tract caused approximately the same number of deaths. Cancer of the stomach alone causes about 30,000 deaths per year. The number is approximately one-fourth of all the deaths from cancer. It is estimated that within the next ten years the number of deaths from cancer of the stomach will be increased to 40,000 per annum. This increase is due in part to the longer life expectancy, and with resulting greater span of life there are more patients in the "cancer age." However, despite our better diagnostic ability, we have not materially decreased the number of deaths from cancer of the stomach. It is noteworthy to mention that cancer of the stomach is more prevalent among men than women. *Excerpt: Carcinoma of the Stomach, Dwight B. Shaw, M.D., Pueblo, Colo., Rocky Mountain M. J., Sept.,* 1951.

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Malony, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



Relationship of Voluntary Health Insurance to the Medical Profession

What is the purpose of the Medical Profession, of our hospitals, and of our health insurance plans? When the question is thus plainly stated the answer appears equally plain. They have but one fundamental purpose — *the provision of the best possible medical care to the greatest number of people.* In any consideration of their activities this fundamental purpose must never be lost sight of. Whenever other aims, other purposes are allowed to assume greater importance than the provision of the best possible medical care, we invite just criticism and, still more seriously, we invite failure. In spite of the fact that health insurance plans deal primarily with economic problems, we must always organize and develop, critieize, re-examine and reorganize these plans in answer to the question — "Do they help to assure the best possible medieal care?" They can only survive and suceeed when they are so oriented. They will ultimately fail if they are devised *primarily* to serve as collecting ageneies for hospitals, to solve the economie problems of hospitals, to enable doctors to eollect larger fees or to oppose soeialized medicine.

Certainly we must fight socialized medicine; because medicine controlled by politieians eannot provide the best possible medical eare. It eould not be otherwise. Politicians are generally medically ignorant. Through long years of training, experience, and political necessity, they have become dominated by selfish and sectional interests. The best in medical care has never been found along roads designated by such guide posts. But neither can the medical profession or hospital management pursue a selfish eourse and achieve the best in medical care. We have been too content to accept our medical care as the best in the world and not sufficiently anxious to improve and extend it to the greatest possible extent. We have been much too slow in reeognizing that a man has as mueh right to insure himself against the unexpected expense of illness as he has to proteet himself against the unanticipated catastrophe of his home burning down.

A negative approach to these problems is not enough. We cannot merely find fault with and oppose those plans of which we do not approve. We must continue to improve, expand and extend the voluntary insurance programs along with other plans to achieve the best possible medical care. Each plan, each program, each extension, and each limitation must be examined in that light. Each must answer the question: "Does it serve the medical care, the health and well being of the American people?"

Our programs will never achieve their goal. They must steadily grow and progress as medicine advances and as the needs of our people change. This is a task which will never be accomplished — never be finished. Yet if we of the hospitals and of the medical profession will steadily advance our plans toward this goal we need have no fear of the successful imposition of governmental control of medicine.

There are several deficiencies in our present programs of voluntary health insurance. These programs provide hospital care and in a considerable measure cover the costs of professional service for people who are employed. But what happens to the medical care of these same people, to the plans and to the operation and economics of our hospitals when people become unemployed, particularly in periods of extensive unemployment? These programs provide care for limited periods but do they provide care for the chronically ill? Neither do they provide for the medical care of the aged, who are steadily becoming more numerous and who are often ill. It would hardly seem compatible with our ideas of avoiding governmental medicine and with the aims of voluntary health insurance for us to fall back on governmental charity for the unemployed, the chronically ill and the aged sick. Obviously these are fields in which extension of voluntary insurance should be carefully studied.

Although our present voluntary insurance plans provide for hospital costs, they provide only for operating costs. The Blue Cross covers nursing care, food, drugs, operating room costs, heating, administration, etc. But it does not cover building replacement costs. Our present hospitals will not last forever and do not even now provide adequately for the demands made upon them. They must be enlarged, and replaced. How is such expansion to be financed? Any voluntary insurance program for hospitalization which does not provide for building costs is not carrying the full burden of the costs of hospital care, and leaves us with the serious unsolved problem of adequate hospital facilities in the future. Federal Governmental subsidies for such purposes are not the way to avoid governmental control of hospitals and medical care.

One may ask, "What is the relationship of such problems to the medical profession?" and, although it is true that such problems are fundamentally community programs, they are also the problems of the profession. Hospitals are the doctors' work shops. Good hospitals, adequate in size and equipment, are essential to the practice of good medicine.

There are various factors which endanger the success of these programs and many of these affect the doctor directly. It is important that he recognize these dangers and constantly be on the alert to avoid them if these plans are going to succeed.

It is important that every one recognize that these voluntary insurance plans (Blue Cross and Blue Shield) are mutual efforts. They are no more a way of obtaining something for nothing than is aid from the Federal Government. Every service provided through these insurance plans has to be paid for by the members of the plans by the recipients of the services. These plans are merely means of avoiding large, unexpected, unplanned, expenses at one time and of spreading this expense over a larger number of people, for the time being, and over a number of years. Today you help your neighbor pay the costs of his illness, tomorrow he helps you with yours. Accordingly, every unjustified expense either necessitates a further increase in the insurance premium which the patients must pay or endangers the economic stability of the plans. In order to avoid unnecessary expense and to avoid burdening the plans with limited costs which the patient can in some measure control, the plans have not included certain hospital and medical expenses. Thus the plans do not cover visits to the doctor's office or the doctor's visits to the patient's home. They do not cover diagnostic tests and do not cover hospitalization solely for diagnostic purposes. To include these and some other expenses which are not covered would increase the premiums greatly. For the patient or the doctor to induce the plans to pay these expenses by subterfuge, likewise can only increase the cost of the

plans. If these plans are to succeed, if they are to avoid economic disaster, the doctor must refuse the patients' requests to certify falsely that periods of hospitalization for diagnosis are for purposes of treatment, he must refuse to be a party to dishonest attempts to have the Blue Cross pay for x-ray examinations or special tests and studies which are not essential to the treatment of the patient's illness. He must refuse to acquiesce to the patients' requests for gastrointestinal x-ray examinations, to electrocardiograms, or to any other tests, at the expense of the plans, solely to satisfy the patients' curiosity or neurotic apprehensions. He must be on guard against the unnecessary administration of expensive drugs or the continuation of such drugs when they are no longer needed. He must not connive with the patient to prolong his hospital stay unnecessarily merely because "Blue Cross will pay for it." These are essential obligations upon the physician and upon the patient if these programs for voluntary independent insurance for medical care are to survive and continue to grow.

There are other responsibilities upon the profession if their plan, the Blue Shield, for the payment of medical fees is going to fulfill its purpose. Neither the Blue Cross nor the Blue Shield should serve as a means of increasing medical fees. The fact that a patient has voluntary health insurance should never cause the fees for professional service to be raised. To do so defeats the purpose of the Blue Shield and the Blue Cross. Unfortunately there has always been the very occasional physician who charges excessive fees. Such instances are now being thrown into bold relief when the patient compares such fees with those allowed by the schedules of the Blue Shield. Patients, therefore, complain to the Blue Shield and to the medical profession about such discrepancies. Obviously there will often be differences between the fees charged by the physician and those allowed by the Blue Shield schedule, as the schedule is designed to cover completely the medical costs of only those in the lower income bracket. However, fees which are 10-15 or even 20 times those paid by the Blue Shield are probably excessive for most people. Among the duties of the Professional Relations Committee for Blue Cross-Blue Shield of the Chicago Medical Society is that of examining such discrepancies, obtaining full information about them and endeavoring to adjust them in instances where this committee of the Chicago Medical Society believes the fees charged to be excessive. Fortunately, such instances are rare indeed and the cooperation of the medical profession with this committee has been excellent, with very few exceptions. In addition this committee also has as its purpose the explaining of various aspects of these voluntary health insurance plans to the professions. The committee also brings to the Blue Cross and the Blue Shield the suggestions of the profession and endeavors to assist in the mutual cooperation of the two in this important program.

HAND INJURY

The principles of the immediate treatment of injuries of the hand are identical with those of compound injuries elsewhere, and it is those principles that I wish to stress rather than specific details. They can be stated very briefly:

1. Protect the open wound from infection.
2. Stop bleeding.
3. Determine the extent of injury.
4. Transform the contaminated wound into a clean wound.
5. If the latter can be accomplished, bring fractured bone fragments into position, repair the injured structures, and close the wound.
6. If one is uncertain as to the cleanliness of the wound, reduce fractured bone fragments but leave injured tendons and nerves undisturbed, and either leave the wound open or bring wound edges together without tension.
7. Cover the entire injured area with a large compression dressing.
8. Apply a splint to keep the part at rest.

Excerpt: Immediate Treatment of Hand Injuries, Sumner L. Koch, M.D., Chicago, Pa. M. J., Aug., 1951.

CORRESPONDENCE



ORGANIZATION OF AUXILIARIES IN ILLINOIS

The Woman's Auxiliary to the Illinois State Medical Society was formed twenty-three years ago. We were organized because the Illinois State Medical Society believed that a Woman's Auxiliary could: (1) Assist the Illinois State Medical Society in the advancement of the prevention of disease. (2) Aid in securing better legislation indicated in the pursuance of these ends. (3) Do such other supplemental work as should be determined from time to time by the Medical Society in the advancement of professional interests. (4) Contribute to the Benevolence Fund.

Gradually membership in the Woman's Auxiliary has increased and as our numbers grew our capacity to accomplish the tasks given was augmented. Now, events loom before us that warn that grave responsibilities lie ahead. Every doctor's wife is needed. For this reason the organization committee know that during this year a real effort must be made to form new Auxiliaries in every county where one does not already exist. In counties where, for one reason or another, it is not feasible to have a Woman's Auxiliary, doctor's wives must be urged to become "members-at-large."

Being a "member-at-large" is a rather poor substitute for membership in a County Auxiliary — but far better than no membership at all. Members-at-large are sent literature from time to time. Their chairman who is an appointed member of the state executive board is the link between them and the active Medical Auxiliary. Their dues of two dollars are payable to the state treasurer, Mrs. S. M. Hubbard of Ridgefarm, Illinois. If you cannot join a County Auxiliary, make it your personal obligation and pleasure to support the Woman's Auxiliary to the Illinois State Medical Society by becoming a "member-at-large."

Since the organization committee is composed of the councilors, chairmanned by the president-elect, those counties wishing to form an Auxiliary should contact their councilor. The councilors are as follows: First district, Mrs. Douglas Hurley, Elgin; second district, Mrs. R. E. Davies, Spring Valley; third district, Mrs. Samuel G. Plice, Elmwood Park; Mrs. James P. Simonds, Chicago; Mrs. J. Van Prohaska, Chicago; fourth district, Mrs. William Johnson, Galesburg; fifth district, Mrs. Henry Berchtold, Springfield; sixth district, Mrs. Carl Hagler, Quincy; seventh district, Mrs. C. H. Black, Salem; eighth district, Mrs. A. R. Brandenberger, Danville; tenth district, Mrs. R. B. Ellis, East St. Louis; and eleventh district, Mrs. George Carlin, Joliet. In the absence of a ninth district councilor we rely on the Medical Society councilor, Dr. Burtis E. Montgomery of Harrisburg.

Our oranization committee cannot reach the goal we have set without much help. Already the councilors of the Medical Society have

pledged their assistance. Won't you too assume your part of the responsibility? Let us try to have every doctor's wife an Auxiliary member. There is a strength in numbers. A common aim and great purpose give those numbers the opportunity to do unlimited good — and remember — "goodness is the mightiest practical force in the universe."

Mrs. Harlan English
President-elect and Chairman of Organization of the Woman's Auxiliary to the Illinois State Medical Society.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR JANUARY

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the January schedule of clinics for physically handicapped children. The Division will conduct 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. From private physicians, who are certified Board members, are selected the clinicians. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services:

The January clinics are:

January 2 — Joliet, Will Co., T. B. Sanitarium

January 3 — Mt. Vernon, Masonic Temple

January 3 — Clinton, Christian Church

January 3 — Sterling, Community General Hospital

January 4 — Aurora, Copley Hospital

January 8 — Peoria, St. Francis Hospital

January 8 — East St. Louis, St. Mary's Hospital

January 9 — Alton, Alton Memorial Hospital

January 9 — Hinsdale, Hinsdale Sanitarium

January 10 — Springfield, St. John's Hospital

January 10 — Elmhurst (Rheumatic Fever), Memorial Hospital, DuPage County

January 11 — Chicago Heights (Rheumatic Fever), St. James Hospital

January 15 — Danville, Lake View Hospital

January 15 — Quincy, St. Mary's Hospital

January 16 — Evergreen Park, Little Company of Mary

January 17 — Rockford, St. Anthony's Hospital

January 17 — Cairo, Public Health Building

January 22 — Peoria, St. Francis Hospital

January 22 — Salem, American Legion Hall

January 24 — Bloomington, St. Joseph's Hospital

January 25 — Chicago Heights (Rheumatic Fever), St. James Hospital

January 29 — Effingham (Rheumatic Fever), Douglas Township Building

January 30 — Springfield (Cerebral palsy), Memorial Hospital

FELLOWSHIP IN INDUSTRIAL MEDICINE

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships offered to qualified candidates who wish to pursue a graduate course of instruction in preparation for the practice of Industrial Medicine. Any registered physician, who is a graduate of a Class A medical school and who has completed satisfactorily at least two years of training in an hospital accredited by the American Medical Association may apply for a Fellowship in the Institute of Industrial Health. (Service in the Armed Forces or private practice may be substituted for one year of training.)

The course of instruction consists of a two-year period of intense training in Industrial Medicine, followed by one year of practical experience under adequate supervision in industry. Candidates who complete satisfactorily the course of study will be awarded the degree of Doctor of Industrial Medicine.

During the first two years, the stipends for the Fellowship vary, in accordance with the marital status of the individual, from $2,100 to $3,000. In the third year the candidate will be compensated for his service by the industry in which he is completing his training. Requests for additional information should be addressed

to the Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19, Ohio.

X-RAY VU-GRAPH FOR COUNTY SOCIETIES

The Illinois Tuberculosis association is offering to local medical societies an x-ray Vu-Graph for use at their meetings.

The Vu-Graph projects an enlarged x-ray on a screen for study by groups. The projector is simple to operate and is so designed that the speaker can handle his own x-rays while facing his audience.

The projector is being offered for the medical societies' use at their meetings in connection with a speaker on tuberculosis or a meeting in which they plan to use x-rays. There is no charge for this service.

Arrangements for use of the projector should be made not less than one month in advance through the county tuberculosis associations.

GRANTS-IN-AID, CANCER RESEARCH

The American Cancer Society, Illinois Division, Inc., has received two legacies, one in the amount of $20,000 from the Ernest Kruetgen estate and one for $5,000 from the Bessie Kultgen estate. In each instance the will specifically stipulates that these monies must be expanded for cancer research only.

The American Cancer Society, Illinois Division, Inc., will, accordingly, receive applications for grants-in-aid to support responsible cancer research projects to be considered by a special committee.

Applications should contain full details concerning the nature of the project and what is hoped in the way of accomplishment. Sufficient information should be supplied to assure the committee that personnel concerned in the research is qualified and that adequate facilities are available.

Applications will be received until January 1, 1952, and should be addressed to

John A. Rogers, M.D., Executive Director
American Cancer Society, Illinois Division, Inc.
139 North Clark Street, Chicago 2, Illinois

CIVIL SERVICE EXAMINATIONS FOR PHYSICIANS

Physicians, psychiatrists, and tuberculosis control physicians are being offered immediate civil service employment with the State of Illinois through continuous examinations.

Candidates will not take a written examination. Following an oral test or interview, positions are offered immediately to those who qualify.

Advantages offered civil service employees with the State of Illinois include research and promotional opportunities, paid vacations, pay increases, regular hours, minimum expenses, and liberal retirement benefits.

Application forms may be obtained from the Illinois Civil Service Commission, Armory building, Springfield, or from local offices of the State Employment Service. Applications will be accepted until further notice.

DINNER TO HONOR HESS

Friends and former students of Dr. Julius H. Hess, Professor Emeritus, Department of Pediatrics of the University of Illinois College of Medicine, announce a testimonial dinner in his honor, to be given on January 23, 1952 at the Congress Hotel, at 6:30 P.M. Those wishing to attend, please send a check for $10.00 made payable to the Dr. Julius H. Hess Banquet Fund, to Dr. Samuel J. Hoffman, 629 South Wood Street.

ORIGINAL ARTICLES



The Management of Deafness

George E. Shambaugh, Jr., M.D.
Chicago

The management of any case of impaired hearing proceeds in three successive steps:

1. Clear-cut, accurate and complete diagnosis.
2. Correction of the hearing defect where possible by medical treatment.
3. Audiologic rehabilitation where medical therapy cannot restore practical hearing.

The Rinne and Schwabach tuning fork tests are still the otologist's most important means for diagnosing a pure inner ear loss from a conductive loss with or without a superimposed perceptive component. With improved audiometry we are coming to place additional reliance upon the *air-bone gap* for this differentiation. In a pure perceptive loss the air and bone audiograms *interweave*, with no significant air-bone gap. A consistent air-bone gap of 20 decibels or more means a lesion of the sound conducting system, the size of the gap measuring the degree of the obstruction to sound conduction, while the loss by bone measures the perceptive component.

If there is a conductive loss, as determined by the negative Rinne test and normal or prolonged Schwabach, with an air-bone gap in the audiogram, the exact cause for this obstruction to sound conduction is ascertained without too much difficulty in most cases from the history and inspection of the ear, remembering that there are 6 main causes for conduction deafness:

1. Occlusion of the external auditory meatus.
2. Perforation of the tympanic membrane.
3. Occlusion of the eustachian tube (secretory otitis).
4. Suppurative otitis media.
5. Adhesive otitis media (the end result of a previous suppuration).
6. Otosclerosis.

Should the hearing tests, particularly the bone conduction audiogram, show a pure perceptive loss, or a perceptive loss superimposed on a conductive loss, the otologist should endeavor from the history and from the shape of the audiometric curve to determine the cause for the nerve degeneration. This is not so easy, for in at least a third of the cases seen no apparent cause for the nerve deafness can be found.

The complete otologic diagnosis should include an exact measure of the perceptive and

Presented before the Section on Eye, Ear, Nose and Throat, 111th Annual Meeting, Illinois State Medical Society, Chicago, May 23, 1951.

conductive component in that case, a definite diagnosis of the cause of the conductive loss, if present, with a statement of the probable cause for the perceptive loss when this can be determined. Finally a prognosis should be given for the possibility of medical restoration of hearing, and of the future prospects for further deterioration or for a stable level of hearing.

Concerning the possibilities of medical therapy of deafness, Canfield[1] recently stated that "not more than 10% of those whose hearing is impaired can expect unaided improvement in hearing". To compare this rather pessimistic view with actual clinical experience, the routine patients complaining of impaired hearing seen by three otologists (Dr. E. L. Derlacki, Dr. A. L. Juers, and the author) in the course of one year (1950) were reviewed.

Of the 1046 patients examined, 420 (about 40%) were found to have a pure perceptive type of loss. Nearly a fourth of these (23.6%) were diagnosed as labyrinthine hydrops on the basis of a horizontal type of curve with marked fluctuations in hearing, often with attacks of vertigo, with fullness or pressure in the ear and with diplacusis. In 12 of the 99 cases of hydrops an allergic etiology was suspected and treated, and the hearing improved an average of 15 decibels for the speech frequencies. However, it is difficult in all cases to be sure that the improvement resulted from the medical therapy since the hearing in hydrops tends to fluctuate spontaneously.

Labyrinthine hydrops is the only form of nerve deafness that can be influenced by medical treatment. As far as I know there has never been a proven case of hearing improvement from vitamin therapy.

The 10.9% of cases of nerve deafness due to acoustic trauma are noteworthy because this is one of the few kinds of nerve deafness that is definitely preventable by routine testing of the hearing of employees in noisy industries to discover and protect those with tender ears susceptible to this sort of damage.

Among the miscellaneous causes for nerve deafness were 3 cases of psychogenic loss. In military life psychogenic deafness is quite important and frequent, but in civilian life it is rare, comprising only a fraction of 1% of all cases.

In contrast to the 40% of cases with a pure perceptive loss, where medical treatment is generally futile, there were 626 cases or about 60% of the total number seen, with a conductive loss, and the majority of these could be improved substantially by medical or surgical treatment.

The largest group with a conductive loss were 453 patients with otosclerosis. Although this series was somewhat selective in that many of these patients came or were referred for possible fenestration, nevertheless the high incidence of otosclerosis as a cause for deafness is noteworthy.

The second most frequent cause for conduction deafness was occluded eustachian tube with secretory otitis in 52 cases or 8.3% of the patients with a conductive loss. Treatment consisted of inflations with control of any nasal allergy; adenoidectomy in 5 cases, paracentesis in 3 cases and radium to the eustachian orifices in 1 case. Secretory otitis practically always responds to therapy with normal hearing. In 33 cases retested after treatment the hearing had improved an average of 19 db for the speech frequencies. Our experience agrees with that of Dr. Gordon Hoople who found that secretory otitis is a frequently overlooked cause for impaired hearing in all age groups. It is the only form of deafness benefited by inflations. Allergy was an important factor in the tubal occlusion of many of our cases.

Adhesive otitis, the end-result of a previous suppurative otitis media, accounted for 50 cases, or 7.9% of those with conduction deafness, and none were improved by therapy.

There were 34 cases (5.4%) of chronic suppurative otitis media, about one third of which (13 cases) were improved an average of 18 db for the speech frequencies by clearing the infection by conservative treatment or by surgery.

Perforation of the tympanic membrane caused 27 cases (4.3%) of conduction deafness. Closure was successfully accomplished in 7, with an average gain of 14 db for the speech frequencies. Time does not permit discussion of this group except to say that the technic of closure as developed by Dr. Derlacki has been used in more than 100 cases, with successful results in 70%, usually with a very useful restoration of hearing.

The conduction loss was due to occlusion of the external auditory meatus in 10 cases (1.6%).

1. Canfield, N.: Audiology, the Science of Hearing, Acta Otol. Suppl. 76, 1948 (6-16)

4 due to cerumen, and 6 to congenital atresia. Two of the latter were operated with an average gain of 36 db for the speech frequencies.

Of the 453 patients with otosclerosis, 66 cases or about one in seven, were unsuitable for surgery on account of advanced nerve degeneration. In 54 cases (11.9%) the hearing loss was not yet sufficient to require surgery, while in 333 cases (73.5%) fenestration offered the chance of a useful hearing improvement. Since patients with otosclerosis may be helped by a hearing aid, the fenestration operation is very definitely an elective procedure. On the basis of speech tests made with the patient's hearing aid before surgery, and without the aid after operation, we have found that on the average in "A" cases ideally suited for operation fenestration provides slightly superior hearing to a hearing aid. There were 210 "A" cases, of whom 144 chose surgery, 67.5% reaching the 30 db level of practical hearing at the most recent test. There were 87 "B" cases, with slight nerve degeneration, of whom 49 were operated, 28.9% reaching practical hearing. There were 36 "C" cases of borderline suitability, of whom 12 chose surgery, though without the expectation of reaching practical hearing, and none did. Of the 205 patients with otoselerosis who elected surgery, 53.4% or roughly half were fully rehabilitated and reached the 30 db level of practical hearing.

Audiological rehabilitation, the third step in the management of deafness, is indicated for those who after the possibilities of medical treatment have been exhausted, still have a handicapping hearing impairment. Time does not permit more than a mention of the four important facets of this important field: hearing aid evaluation, auditory re-education with a hearing aid, lip reading and speech correction.

In conclusion, roughly 40% of patients seen in 1 year in an otologic practice had a hearing loss that could be improved substantially by medical therapy. From this experience we believe that:

1. Modern otology has more to offer the hard of hearing patient than is sometimes appreciated.
2. Enough cases of unrecognized secretory otitis are seen, or of a previously untreated perforation, or of otoselerosis suitable for fenestration but who had previously been diagnosed as ineurable nerve deafness, to believe that inaccurate diagnosis is an important cause for failure to achieve the optimum results from medical management.

DISCUSSION

Dr. William F. Hubbel, Decatur: I would like to ask Dr. Shambaugh what has been his experience with radium.

Dr. Shambaugh: We use radium in the nasopharynx in only occasional cases of secretory otitis in children where thorough surgical removal of adenoid tissues already had been carried out.

Dr. William A. McNichols, Dixon: What do you think of Vitamin A and in how many cases have you tried it?

Dr. Shambaugh: We have used Vitamin A in cases of deafness but have yet to see any case where it was of benefit. In our experience there were no vitamins which were effective in the treatment of deafness.

Question: What do you mean by weak histamine?

Dr. Shambaugh: We use histamine according to French Hansel's technic, diluted 1 to 1,000,000 up to 1 to 100,000,000.

Question: Do you use histamine in preference to house dust for the treatment of nasal allergy?

Dr. Shambaugh: No. The majority of non-seasonal nasal allergies due to house dust sensitivity respond very well to dilute house dust extract.

Question: What about the question of secretory otitis media?

Dr. Shambaugh: First, determine its cause and remove it — such as hypertrophied adenoids or a nasal allergy. Secondly, repeated inflation with paracentesis if the ear continues to be filled with fluid.

Question: How do you close perforations of the tympanic membrane?

Dr. Shambaugh: We are using a technic first described by Dr. Linn of Des Moines, Iowa, modified by us. The margins are carefully cauterized with 50 per cent trichloracetic acid followed by the application of a pledget of cotton which is kept moist with dilute alcohol or urea solution. The cautery is repeated at weekly intervals until the closure is complete.

Complications of Puerperium

Conrad G. Collins, B.S., M.S., M.D., Jason H. Collins, B.S., M.D. and Frank G. Nix, M.D.
New Orleans

The marked decrease in maternal mortality in the United States in the past fifteen years has come about by a keen awareness of the major causes of death in obstetrics prior to and during that period, and the institution of measures both prophylactic and curative to combat those causes. Any further reduction in the mortality and morbidity will be accomplished only by a critical analysis of the many remaining causes of mortality and morbidity and the quest for, and application of, newer procedures and therapeutic measures. In the main, improvements in the past fifteen years have been accomplished by a slight but definite increase in surgical procedures as applied to obstetrics, the increased use of blood transfusion and the advent of chemotherapy. Also the great majority of women are now being delivered in hospitals by special trained attendants. The use of the Waagenstein suction, blood transfusion, intravenous administration of fluids, early ambulation, surgical incisions from episiotomy to total hysterectomy at the time of cesarean section, and antibiotics, have brought new benefits and also new complicatons. Morbidity in the puerperium, post partal or post abortal, is frequently a forerunner of mortality. Early recognition of the causes of morbidity and the judicious application of therapy most frequently defeats mortality.

The presence of fever, increased pulse rate or respiratory rate, in the puerperium is usually the first indication of impending morbidity and perhaps mortality. Careful checking and interpretation of these observations, constant attention to parturient charts and complete physical examination, will mean earlier diagnosis, earlier application of therapy, and be productive of better results. Because a patient has had a baby or abortion is no reason to focus our entire attention upon the female pelvis and birth canal as a possible cause of the complication. The appearance of any sign or symptom demands a thorough head to foot physical examination of the patient. In fact many areas of the body must be examined daily in an attempt to discover signs and symptoms when they first appear, if the decrease in maternal mortality is to continue.

Eyes.—In many cases jaundice appearing in the sclerae will be the first indication of a complication. The appearance of jaundice in the puerperium may mean hemolysis from incompatible blood, sickle cell disease, a hemolytic blood stream infection or an infection by Bacillus Welchii. Rarely the concomitant appearance of jaundice and parturition may signal the appearance of infectious hepititis or homologous serum reaction. Jaundice as a result of absorption of blood pigments by the peritoneal cavity from blood not removed at the time of laparotomy is occasionally seen, especially in cases recovering from operation for ectopic pregnancy. The same is true in cases having had blood loss prior to and at the time of cesarean section into the abdominal cavity, which blood has not been thoroughly removed by suction at the time of laparotomy. We still see an occasional case of B. Welchii infection and occasionally cases of marked blood stream infection by hemolytic streptococcus. The latter usually die early exhibiting the characteristics of the Waterhouse-Friderichsen syndrome. Reactions from blood transfusion are ever present and sickle cell disease, the great masquerader, very frequently simulates postpartal infection. In the presence of jaundice a study of a blood preparation for sickling, and blood cultures for hemolytic strep and B. Welchii are adamant. It might be stated here that all cases of criminal abortion admitted to our service are routinely given combined mixed tetanus and gas gangrene serum on admission. Though we have not completely eliminated the presence of those two serious complications, cer-

From the Department of Obstetrics and Gynecology, Tulane University of Louisiana, School of Medicine, The Tulane Unit, Charity Hospital and the Ochsner Clinic, New Orleans, Louisiana.

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tainly we believe over the period of years the constant use of serum has helped lower the incidence of these complications and mortality there-from.

Oral Cavity.—The increased frequency of usage of aureomycin has been followed by an increase in number of reports of vaginitis and oral pharyngitis due to mycotic infections and/or allergy. The decrease in the normal bacterial flora of these cavities by the use of antibiotics seems to allow for unrestricted growth of candida albicans or cryptococci. Certainly in any case where this drug is being used, frequent examinations of these cavities are indicated. Therapy with gentian violet, propion jel, and in some cases, antihistimines, will produce the desired results.

The increased use of the Waagenstein suction tube and nasal oxygen together with poor oral hygiene in some patients allows for drying of the buccal mucous membrane. Attention to fluid balance and oral cavity hygiene should all but eliminate acute parotitis. Though infrequently seen, the high mortality rate formerly associated with this disease makes it one of the major complications of the bed patient. Routine palpation of the parotid glands daily postoperatively or postpartally is essential. The early detection of tender areas in this gland and early institution of therapy offers a much better prognosis. Formerly when this condition had to be treated by incision and drainage of the abscesses once they were found, or the application of radium or x-ray to the involved areas, the mortality was high, being variously placed at from 25 to 30 per cent. However, by means of early detection and the early use of potassium iodide to increase salivation, and penicillin, this complication should no longer be as lethal as formerly. We have seen one such complication only as late as a few months ago. It was only by means of routine palpation of the parotid gland as performed by our service that it was detected early and the prompt institution of therapy not only controlled the infection but the patient's hospital stay was not increased.

Neck.—During the daily examination of the patient stiffining of the muscles of neck and jaw should be sought out. The increased use of spinal, saddle block and caudal anaesthesia increases the potentialities of chemical and infectious meningitis. At the first sign of rigidity of neck muscles spinal fluid examination is indicated. Trismus of the jaw as well as rigidity of the neck is indication of tetanus. Post partal or post abortal tentanus is still a clinical entity observed by us. To reiterate, prophylactic mixed tetanus and gas gangrene serum is utilized in all cases of criminal abortion admitted to our service. Tetanus is combatted by penicillin, intravenous anaesthesia, curare and curare like drugs aided by tracheotomy in severe cases.

Breast.—We belong to the group who believe that engorgement of the breast is at times accompanied by a moderate to high fever. Though definite scientific proof to substantiate this belief is wanting, nevertheless we cannot entirely disregard the fact that patients having fever postpartally, coincident with the marked swelling and congestion of the breast, improve rapidly if the breasts are decompressed by the use of dehydration and/or breast pump. Certainly we feel much happier if we have a patient having postpartal fever and we find congested breast than if we do not, because in the vast majority of these patients the simple measures described before will not only produce relief of the pain in the breast but also be accompanied by a rapid and sustained drop in temperature. This is no reason however not to complete the physical examination if congested breasts are found. Congested breasts may be incidental and the true etiological factor disregarded. Occasionally, at a later date cracks and fissures in the nipple may be accompanied by cellulitis of the breast. Here again in addition to dehydration the use of antibiotics produces a rapid cure. In some patients, the occasional one fortunately, fever will not be detected for two to three weeks following delivery and a deep-seated breast abscess found on examination. Here as in the days prior to antibiotics incision and drainage of the abscess is needed.

Chest.—Minute examination of the chest in patients having postpartal rise in pulse, temperature or respiratory rate for pneumonia, atelectasis, infarction or embolism is compulsory. As infarction is often silent, routine chest plates on all postpartal or postabortal patients having fever is indicated and if the symptoms fail to improve in two to three days, repeat x-ray of the chest is necessary. Often the roentgenographic evidence of proven infarction cannot be made until 48 hours after the infarct has occurred.

In postpartal or postabortal pneumonia the aid of the internist is needed and the success attained by use of chemotherapy in pneumonia is legion. Atelectasis however still remains a formidable complication. Ideally every woman, at the time of delivery, should have anasthesia with her stomach empty but this is not feasible in all cases. True we can restrict or eliminate the intake of food and fluids in patients in labor who appear at the hospital early, however, as we all know, some women will go into labor after a very heavy meal or will eat a heavy meal even though they are in labor, and in some instances their physicians will allow them to have food and drink while in labor. We are all cognizant of massive collapse of the lung due to aspiration of vomitus at the time of delivery, however, if a small amount of ingested material is aspirated only a patchy atelectasis will result and infrequently the effects of this will not be evident until 48 to 72 hours postpartal or postabortal. The signs and symptoms of atelectasis vary from immediate shock and cyanosis when a large bronchus is plugged, to impaired respiration, increased respiration and fever, 24 to 48 hours after aspiration of the material into the smaller bronchioles. The therapy of this condition, if it occurs immediately post delivery, while the patient is in the delivery room and under the anesthetic, is to tilt the head downward and clear the passage by means of an airway and suction and, if at all possible, bronchoscopic aspiration of the plug. For the mild cases or those of moderate severity the patient's affected side should be placed upright and the patient slapped soundly on the back over the affected area. This may result in loosening of the plug which the patient will promptly cough up. Occasionally bronchoscopic examination is needed in these cases. For those with the mild scattered patchy atelectasis, oxygen, blow bottles, and prophylactic administration of antibiotics, is the therapy of choice.

In dealing with the pregnant woman, more types of embolism are encountered than in any other person. Embolism may occur from fat, air, amniotic fluid or blood clot. As the first three mentioned are usually encountered prior to or concomitant with delivery our discussion of embolism will be limited to the type most frequently seen postpartally, that due to blood clot. An area in the chest diagnosed by physical examination or roentgenogram as pneumonia or atelectasis should be considered as infarction until proved otherwise. This is only made possible by a complete survey of the pelvis and the legs as will be described later. Confirmation of infarction demands immediate therapy. If one believes in anticoagulants, they should be used; if one believes purely in vein ligation, ligatures proximal to the clotted vein should be applied. If one believes in both methods he should apply one or both judiciously.

Abdomen.—An incision in the abdomen is not infrequently the cause of post-operative fever or increased pulse rate. This may be due to seroma, hematoma, wound abscess, wound dehiscence or evisceration. In published reports, evisceration is accompanied by a very high mortality. On our service, however, since we have adopted the policy (1946) that any time an abdominal incision is to be explored for the possibility of one of the factors mentioned, it is to be explored only in the operating room. Exploration is not to be done in the patient's room or on the ward. No longer is a probe or a curved pair of forceps thrust between the sutures or a few sutures removed and the wound inspected while the patient is in her own bed. Whenever any complicating factor of the abdominal incision is suspected an operating room is set up and the patient brought to the operating room, the sutures removed, and the wound inspected there. If a seroma is found, adequate drainage is established. If a hematoma is found, it is emptied completely, as is an abscess. If a mild wound dehiscence with separation of only the fascia is found, the wound is resutured. In this way we have been able to uncover cases of evisceration that by inspection and palpation in the patient's bed would not have been discovered early. We have not had but one fatality from evisceration since January 1, 1946. This case eviscerated two weeks postoperatively after having been transferred to the medical service for control of her diabetes. To reiterate, wound evisceration can be accompanied by a high mortality rate. This we believe is due to the shock incurred when intestine and omentum is protruding between a gaping wound for hours before the patient is brought to the operating room. Patients do not die from evisceration but from late detection of evisceration.

Whether or not an incision is present in the

abdomen, the abdomen should be inspected daily for distention and peristalsis; ileus being combatted by Waagenstein suction and intravenous fluids. Peritonitis is treated by the same agents plus penicillin and one of the mycins. The combined antibiotic therapy being much more efficacious as a larger bacterial spectrum is covered. Any time pus is obtained, smears and cultures should be made in order to identify the organism. Formerly this was done only as an investigative procedure to establish the types and frequency with which organisms produced infection. Today it is very important to obtain such information, as inefficacy with one form of antibiotic means that sensitivity tests can be run on the cultured organisms and perhaps an antibiotic that might be more efficacious suggested. In all cases of abdominal distention, with or without peristalsis, a scout film of the abdomen should be taken. This abdominal roentgenogram should also take in the subphrenic areas, so that an elevated diaphragm from air or pus can be detected. We have seen air under the diaphragm as a result of perforation of the uterus or ruptured uterus. An elevated diaphragm from postabortal or postpartal subphrenic abscess is occasionally detected. The possibility of an abscess in the abdomen elsewhere should always be considered. In particular, patients known to have had ovarian cysts of fibroids should be carefully watched postabortally or postpartally because it is at this time that the cysts most freqently undergo torsion. Diminution in the size of the uterus and release of intraabdominal pressure seem to favor the increase susceptibilty of ovarian tumors to torsion. Of course any time a fibroid is present one must think of the various types of degeneration they might undergo.

Vulva and vagina.—Careful inspection and palpation of the vulva and vagina for hematoma of the vulva, infected episiotomy, or thrombosed veins, is important. Not only is the examination important but the method of examination is important. We have seen patients die as a result of hematoma of the vagina, the hematoma extending up into the broad ligament and concealed fatal hemorrhage resulting. An examination of an episiotomy wound for infection or hematoma means examination of this wound with one finger in the vagina and one in the rectum and the incision palpated between the two fingers. One finger in the vagina and none in the rectum will mean that one will miss many cases of infection or hematoma of the episiotomy wound. Also the finger in the rectum will detect impacted feces which in itself can cause postoperative distention and fever. The detection of a thrombosed vein is important as it may be the starting point of a suppurative pelvic thrombophlebitis.

Pelvis.—A not infrequent cause of postpartal fever is retained lochia. When retained lochia ends and endometritis begins is a moot question, however in the parturient with scanty lochial flow and perhaps a rise in the heighth of the fundus we should immediately prescribe an oxytocic in order that the uterus may be made to empty itself of retained clots or placental tissue.

We are always very happy in examining a patient with postpartal infection to find areas of induration in one or both of the parametria, as septic cases of this type, in our experience, offer the best prognosis. Parametritis means that the major portion of the infection is in the lymphatics and that by the use of heat, antibiotics, and transfusions, the vast majority will recover. On the other hand, in marked postpartal infection with a freely movable uterus and with little or no parametrial thickening, we know that the majority of these cases have suppurative pelvic thrombophlebitis and that the infection is in the blood vessels primarily. It is in this type that septic infarction to the brain, kidney, liver and spleen occur, or bacterial endocarditis, or mycotic aneurysms develop. These patients usually die from sepsis. This is the type of patient, who if she does not respond to medical regimen or antibiotics, blood transfusions, fluid balance etc., is subjected by us to inferior vena cava ligation and ligation of the ovarian vessels with good results. In other words, in a case of puerperal sepsis, when no other factor is found to explain the fever, and the uterus is movable with or without the palpation of thrombosed veins in the parametrial area, we have the most seriously ill of all. Pelvic peritonitis is treated the same way as peritonitis of the general abdominal cavity. Certainly cases of puerperal sepsis, where the etiological factor is found to be in the pelvis, should be repeatedly observed and examined, preferably at four to five days intervals, not only to detect thrombosed veins but also to detect ovarian abscess, cul-de-

sac abscesses or parametrial abscess. Should this type of pathology be encountered, incision and drainage, either extraperitoneal or through the cul-de-sac, should be performed as soon as the abscess is diagnosed. Abscesses of the ovary, the parametrium or cul-de-sac, postpartal, can rupture spontaneously into the general peritoneal cavity. A high mortality rate results similar to that seen in ovarian abscesses that develop from other causes and rupture spontaneously into the peritoneal cavity. And last but not least when the vulva and vagina are examined one should be careful to try to detect the presence of crepitation which usually portends a gas bacillus infection.

Urinary system.—Cystitis or pyelitis developing postpartally is a frequent complication. Examination of catheterized specimens of urine for pus, and the sediment for organisms, is mandatory. Fortunately the advent of sulfa drugs and antibiotics have rendered these complications less serious. The great increase in the use of saddle block or caudal anaesthesia has increased the frequency of bladder complications. It takes some time for the bladder to recover and unless these bladders are carefully watched and kept emptied by the use of repeated catherization or indwelling catheters, ability to empty the bladder completely is a matter of days. In this regard, both the use of catheters or overdistention of the bladder with incomplete emptying made a person more susceptible to urinary tract infection. Ninety per cent of the urinary tract infections that we see are due to escherichia coli. These of course respond to therapy with sulfathaladine and sulfadiazine. Occasionally it is necessary to use one of the mycins. A description of the complications arising in the urinary tract will not be complete without a word or two about reactions to blood transfusions and the development of a lower nephron nephrosis. It is true that blood transfusions are saving lives, but it is also true that many deaths are the result of injudicious use of blood transfusion or poor typing or cross matching. When one is not sure about his laboratory, an indwelling catheter placed in the bladder when the transfusion is running with constant observation of the urine is of advantage, for the hemolysis can be detected early and the transfusion stopped. Once lower nephron nephrosis has developed, the patients are treated conservatively, in that we do not use decapsulation of the kidney, the artificial kidney, peritoneal lavage, or lavage of an isolated loop of small intestine. We rely upon a sensible fluid balance regime, consisting of 1,000 cc. of 5 per cent glucose I.V daily, plus an added amount of 5 per cent glucose intravenously equal to the quantity of urine that the patient excreted during the previous 24 hours. Serial cardiograms are taken in order to determine the presence or absence of hyper or hypo kalemia. If hypokalemia develops, then 1.33 gms. of potassium chloride is given intravenously. No saline is given as these patients are having salt retention. In hyperkalemia there is the possibility it may be necessary to use small amounts of sodium chloride despite the fact that the patients already have soduim retention. The diuresis that occurs following recovery of the kidneys is usually observed from the seventh to the twelfth day follow the onset of oliguria or anuria. When it occurs it is particularly important to observe the urinary output as some patients may excrete as much as 8 liters per day and seriously deplete their chloride reserve. This is the time to use sodium chloride intravenously, but not until this does occur.

Extremities.—Examination of the extremities is most important and should be conducted twice daily whether or not the patient has any evidence of postpartal complications. Palpation of the thighs along the course of the femoral veins, palpation of the calf and dorsiflexion of the feet should be performed twice daily. At the first indication of Homan's sign or tenderness along the course of the femoral vein, venous clotting should be considered and the signs and symptoms carefully evaluated. If one believes that intravascular clotting is occurring then anticoagulants or bilateral ligation of the femoral vein should be utilized. Occasionally a thrombophlebitis develops, and here lumbar sympathetic block is utilized. It is to be remembered that in thrombophlebitis of the leg veins, the patient usually calls one's attention to the fact that her leg is swollen and tender, whereas in phlebothrombosis, we have to tell the patient that a complication is developing. We must detect the tender areas, because in phlebothrombosis fatal pulmonary embolism may result before any complaint is uttered by the patient. In thrombophlebitis the clot is firmly attached to the vein wall and a fatal embolism is a rarity.

The extremities, including the buttocks, should be palpated thoroughly as the increased use of intramuscular and subcutaneos injections of therapeutic materials has increased the number of deep seated abscesses encountered. If this is not kept in mind therapy of postpartal fever may be misdirected.

CONCLUSIONS

Though maternal mortality has shown a remarkable decrease in the United States in the past fifteen years, there is still much to be desired. Each new therapeutic measure introduced has in part been responsible for this reduction. However, each new therapeutic measure also carries new complications. Though the incidence of many causes of mortality and morbidity has been lowered throughout the years they have not completely disappeared. Any further improvement in the increase of maternal mortality and morbidity depends upon a knowledge of these factors, and a recognition of the dangers, as well as the benefits of newer methods, drugs or chemicals. There can be no substitute for continued education of general practitioners and specialists. Complete physical examination of the patient and continuance of long established surgical principles has not been replaced by wonder drugs.

IS IT ASTHMA OR CARDIAC FAILURE?

There appear to be no infallible guides by which to differentiate between cardiac insufficiency and asthma as a cause of dyspnea, wheezing and coughing in elderly patients. Many of the symptoms of one condition are also symptoms of the other. Even the results of therapeutic trial cannot be relied upon to establish diagnosis, for drugs effective in treatment of heart disease may also help relieve asthma, and vice versa.

Although there is no single factor that can be considered pathognomonic, there are certain symptoms and results of tests which are more strongly indicative of one condition than of the other. . . .

A. Indicative of asthmatic origin:
 1. A long history of asthma or other allergic diseases.
 2. Other manifestation of allergic reaction.
 3. Sputum tenacious and containing Charcot-Leyden crystals, eosinophils, and Curschmann spirals.
 4. Eosinophilia in blood and secretions (nasal and bronchial).
 5. Circulation time normal or even shortened.
 6. Response, often dramatic, to iodides and sympathomimetic drugs.

B. Indicative of cardiac origin:
 1. History or evidence of cardiovascular-renal disease.
 2. Moist basilar rales in addition to sonorous and sibilant rales.
 3. Sputum more fluid or frothy and even blood-tinged, without Charcot-Leyden crystals or eosinophils.
 4. Respirations more rapid and the two phases less disproportioned.
 5. Circulation time prolonged (whether asthma coexists or not).
 6. Good response to treatment for cardiac insufficiency (including bed rest, digitalis, and mercurial diuretics).

Excerpt: Asthma and Cardiac Dyspnea — A Differential Diagnosis, Frank Perlman, M.D., Portland, Ore., Calif. M., Sept. 1951.

The Practicing Physician and Public Health

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As physicians and public health administrators, we have come to recognize the increasing importance of a closer relationship between community or public health and the practicing physician.

Preventive medicine and public health are the newest branches in medicine and in spite of much misunderstading are rapidly reaching the front line of social progress.

Preventive medicine and curative medicine can not be separated on any sound prinicple, and in any scheme of medical service must be brought together in close coordination. An eminent American surgeon and past president of the American Medical Association a generation ago spoke these words — "prevention runs like a thread of gold through the entire fabric of medicine".

The medical profession has often misunderstood the purposes and objectives of public health, largely because fundamentally its basis seems different from that of medical practice. The latter focused its attention upon disease as it occurs in the individual patient, while the public health physician is more concerned with the health of communities and the broader aspects of disease, the morbidity and mortality rates, environmental protective measures, and the economic loss incident to disease.

The latter field of service requires the cooperation of qualified non-medical personnel, such as the sanitary engineer, the public health nurse, the statistician, the epidemiologist, the health educator, and above all the spirit of the missionary.

The modern public health movement was founded upon the discoveries of the last six decades in the field of bacteriology. With the discovery of the etiological agents of many of the infectious diseases and their mode of spread, it became possible to institute preventive measures, such as water purification, sanitation and food protection. It ushered in a new era in preventive medicine as well as in curative medicine. Recognition of the role of the mosquito as a vector in the spread of yellow fever and malaria, has brought these diseases under control and has made the tropics habitable for the white man. Continuing progress in our knowledge of the virus infections is likewise bringing us closer to their control and possible cure. The effective control of malaria, typhus and other tropical diseases during World War II will form an epic story in preventive medicine throughout the years to come.

With each new discovery in this field of scientific endeavor, the interpendence of the public health worker and the practicing physician has become more marked. This was specially evident with the advent of the public health laboratory, particularly in the facilities offered for diagnostic cultures in diphtheria, typhoid, pneumonia and brucellosis, animal inoculation in tuberculosois, early recognition of the different species of malaria parasites; specific agglutination tests in typhoid, brucellosis, Rocky Mountain spotted fever, the recognition of rabies, the signficance of the Rh factor, serological tests for syphilis, and the preparation of vaccines, antitoxins, specific therapeutic sera. convalescent serum for measles, whooping cough and scarlet fever, and more recently blood plasma and other blood derivatives.

The practicing physican would feel helpless without these diagnostic facilities, and the further aid in the control and treatment of many infectious diseases. Again, without the active cooperation of the practicing physician, the epidemiologist would be likewise hindered in accomplishing the best results.

The introduction of penicillin, a product of the bacteriological laboratory, has revolutionized the treatment of syphilis, gonorrhoea, and many

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of the pyogenic infections; other antibiotics as streptomycin, aureomycin and terramycin offer further promise in the treatment of tuberculosis, brucellosis, as well as certain rickettsial and viral diseases.

We are aware that many scientific achievements in recent years have not as yet had their full impact on medical practice, yet with the increasing use of antibiotics in infections, it is possible to foretell that in the next ten years many infectious conditions, now requiring surgical treatment will be successfully controlled by non-surgical means.

The development of rapid treatment centers for venereal diseases with the careful scrutinizing of the therapeutic benefits of the newer antibiotic remedies, has pointed the way for the treatment of these diseases by the practicing physician either in private office or hospital service, as a part of the general routine of his practice. Hospitalization of these diseases has been reduced to a minimum.

The requirement of premarital and prenatal seriologic tests has distinctly reduced the incidence of congenital syphilis.

With the conquest of the communicable diseases in the early years of life, and more recently of bacterial infections at all ages, the problems of our progressively aging population, the so-called degenerative processes — cancer in all its forms, and the deficiency diseases, are assuming increasing importance in the field of general practice, and are now generally accepted as public health problems. As the life span has been lengthened some thirty years, we are gradually becoming a population of elderly people.

These newer problems of public or community health are definitely changing the pattern of medical practice, and at the same time distinctly modifying the functions of the public health administrator, as well as the character of approach to bring these diseases under control.

The conquest of infectious diseases was most successfully accomplished through mass attack, which, however, can not prevail in applying the principles of preventive medicine in this new field of public health activity.

The early recognition, possible arrest and cure of the degenerative and deficiency diseases, comes properly within the field of the practicing physician. He holds the key position in this new frontier of medical investigation, and is better able to recognize early signs through intensive study of the individual patient, particularly as regards reactions to life and environment and various social influences.

In several screening or case-finding programs instituted by public health agencies in conjunction with special tuberculosis and heart associations, involving particularly mass chest film surveys, many an abnormal chest condition, both of the heart and lungs, is brought more promptly to the attention of the attending physician.

In the field of industrial hygiene, in preventing the hazards of industry, as well as the control of occupational diseases, the practicing physician has the further opportunity of applying the principles of preventive medicine.

Nutrition is likewise becoming a public health problem, as it concerns the health of communities, and likewise assuming an equally important role in the treatment of the individual patient.

Thus the general physician of today, as well as the medical and surgical specialist, are conscious of the increasing part that preventive medicine plays in their professional activities.

Again, the practicing physician recognizes his dependence on the qualified public health worker, as per example.

The follow-up care of a patient with tuberculosis as to the need of further treatment is of frequent concern to the attending physician, particularly if the patient lives at some distance, yet here the public health nurse can best obtain this information for him and likewise influence the patient to continue under medical supervision.

The public health nurse can be of further assistance to the attending physician in advising expectant mothers during the pre-natal period, as well as after delivery and return from the hospital; likewise where one or more cases of scarlet fever or measles occur in a farm home, the public health nurse can best direct the necessary preventive measures.

In rural schools the public health nurse is the only one capable of recognizing abnormal conditions of the eyes, ears, nose, throat, skin and scalp, and bring the same to the attention of a physician.

A few years ago a number of young babies were referred to the University Hospital, Iowa City, with severe cyanosis. This condition of methemoglobinemia disappeared as soon as city

water was used in the feeding mixture. As soon as the babies were returned to their homes, the cyanosis reappeared. This problem was solved by the sanitary engineer, and explained by the excess of nitrates (more than 50 p.p.m.) in the well water used for home feeding.

In epidemics due to milk or water born infection, the nurse and engineer can render invaluable assistance to the epidemiologist and attending physician in determining the source of the epidemic.

The plans that are now being instituted in a number of cities for the fluoridation of the public water supply to prevent the development of dental caries, will require the constant supervision of a qualified sanitary engineer.

In the larger centers of population the sanitary engineer is the guiding force in determining the purity of public water and milk supply, the planning of adequate sewage disposal, the control of flies, and other vectors transmitting disease, as well as sanitary housing.

While the problems of community and individual health are closely related, the administration of maintaining community health requires an organization of specially trained personnel, entirely different from that needed for the treatment of the sick; modern public health service will never fulfill its true purpose until its benefits have been extended to every community in this state and the Nation by the organization of local health services or local health departments.

About such local or commnity units of service there is still much misunderstanding.

In the old days, when we did not have highways and railroads, it was difficult and took a long time to get from one place to the other. Because of this, smaller units like towns, small cities and villages were the places where government conducted its principal business. Epidemics of contagious diseases like typhoid fever, diphtheria and small-pox were the major cause of death. Public health activities were limited to the control of these diseases by isolation of cases, disinfection, quarantine of close contacts and community sanitation. What was needed then was a doctor to diagnose the disease and prescribe the remedy, and a Board of Health to enforce the quarantine rules. It was sufficient in those days to have part-time health officers and to have the local government officials act as the Board of Health.

But things have changed over the years. An intricate network of highways and railroads now makes it easy for us to travel from one end of this State to the other. Trade areas include whole counties and groups of counties. In the field of health, too, we see a different picture. The epidemics of typhoid fever and diphtheria and other contagious diseases, so common fifty years ago, are now rather rare. The major causes of death today with which the modern health department must cope, are the chronic diseases like cancer, heart disease, tuberculosis and diabetes. Instead of one activity — the control of contagious diseases — our modern health departments must concern themselves with many types of activities, such as, maternal and child health, tuberculosis control, nutrition programs, early detection of cancer, heart disease, and diabetes, accident prevention, occupational hazards, public health education, and vital statistics.

To control and prevent untimely deaths from today's major causes of death, requires many special programs and the services of several types of specially trained public health workers. The list of these includes physicians, nurses, sanitary engineers, dentists and dental hygienists, veterinarians, public health educators and statisticians.

In the early years when the sole activity of the health department was the control of contagious diseases, it was quite practical to administer health services within a small geographical area.

As public health activities increased over the years to meet community health problems, it became more and more apparent that the most suitable unit of local government for the support of a variety of health activities was the county. The unit of population for fulltime community health service has been determined at about 50,000 which may include one or more counties, or may be designated as a district.

Community health is now recognized as a local responsibility in the same sense as fire and police protection and the maintenance of public schools and courts of justice.

In order to enable communities to establish local health departments with provision of funds to support the same, permissive legislation is needed in most instances. The local health de-

partment should have the status of an executive department of local government, administered by a fulltime medical director with formal training in public health administration. The health director should be advised by a Board of Health, whose members are representatives of the various groups and health professions in the community. No single professional or business group should constitute a majority. In addition to advising and assisting the health director, the board of health, may enact local regulations.

The health director should be primarily concerned with the development of plans and policies, the provision of overall guidance and stimulation to his staff and effective coordination of their activities.

The various functions of the local health department requires the utilization of different types of specialized personnel, and will depend on the needs of the community, the nature of its special health problems, the size of the population served and the comprehensiveness of the services provided. It may include public health nurses, engineers, sanitarians, laboratory workers, statisticians, physicians, dentists, veterinarians, nutritionists and social workers.

The staff of the health department will be effective only if they are well trained, well paid, chosen on the basis of a merit system that is responsive to the special needs of community health service and provided with adequate leadership on the part of the health director.

It should be understood that the local health department has no direct administrative relationship or responsibility to federal health agencies, and is accountable to the State health agency only for adequate performance of those programs which are delegated to it by State law or regulations. An advisory and coordinating relationship should be maintained between the State health agency and the local health department.

The local health department should be supported entirely if possible by local funds; the acceptance of other funds is entirely within its province to decide. A contribution or tax of one to one and a half dollars per capita per year should be sufficient to maintain a fulltime local health department and secure a modern health service to the community; this is about one-half the cost of fire and police protection.

The main purpose in thus outlining the present concept of community health service, is to indicate, first, that the discoveries in the medical sciences have formed the basis of the several steps in its development; and second, the intimate and integral relationship that the physician bears to every phase of the service. But if this is to be the pattern for community health service in this state and throughout the Nation, it can only attain its fullest purpose if it has the leadership of the medical and allied professions. The physician must be the leader in this new health service and take his place in the driver's seat, not on the sidelines, which sad to say, often prevails today.

It must be evident to many that the practicing physician, however lofty his ideals, has not realized the changes in his environment which medical science and social re-orientation has brought about in this industrial age. In consequence the practicing physician is losing prestige and authority in that broader field of the social aspects of disease. He is being taken from the home of the sick to the hospital ward and his professional office, where he is losing touch with the hereditary, family, home, personal and economic environment of his patients, and where he was formerly better qualified to judge of their importance in disease than he is today. As a result, social agencies are taking over where he left off, the social worker, the nurse, and the various public health services, who must now be specially concerned with the environmental factors and the social implications of health.

It is well known that a larger proportion of physicians have a feeling of social responsibility to the community in which they practice than is found any other professional group; usually, however, the physician does not express this social responsibility, throgh the participation on the boards of worthy health agencies and active participation in civic activities until he has served many years in practice and is approaching retirement.

It is urgent therefore to impress upon practicing physicians the importance of early understanding and active participation in civic activities related to medicine in order that the community can have the benefit of their thinking and the direction which can only be received from those with professional training. This is particularly true in school health. Those who have devoted a great deal of time developing

the different inter-professional relationships centering around child health, and particularly the school health program, are increasingly aware of how little understanding the average physician has of his relationship to the school and to the health department and to the community which both serve.

So frequently physicians have the idea that the only contribution they can make to their community is in terms of medical service. We all know that they can make a far more valuable contribution in the field of community planning for health, the development of acceptable administrative patterns for performing the many public health functions necessary in every community, and by showing an active interest in what goes on in the place where they live.

It seems a pity that physicians with their experience in handling people and a background of specialized training should not use their minds in shaping the pattern of community organization as well as in diagnosing and treating the illnesses of individuals.

Previous reference has been made to the need of skilled non-medical personnel in community health planning, such as the public health engineer, nurse and health educator. In this connection it is often noted in the private practitioner's relationship to the various aspects of the public health program, that he is reluctant to give these non-medical professions credit for their accomplishments.

All such personnel have received special graduate training in one of the ten university schools of public health in this country.

There is often criticism of the health educator, specially in school health problems, because the educator is not trained in medicine. The health educator usually holds a doctor's degree in education or philosophy, and since the average school or other health program is as much education as it is medicine, the physician might question his own lack of educational training and experience.

Together with a mutual respect of each other's function, they can accomplish wonders, while alone, each is relatively impotent eqcept when handling occasional individuals.

These remarks are added with the hope of stimulating physicians to increase their understanding of the social aspect of medical practice as well as to recognize the contributions that can be made to many of their interests by people in the community who have been trained in other professions than medicine.

Our communities will be better places in which to live if all of us are able to apply these aspects of the golden rule to the daily conduct of our community interests.

As a final comment, in considering the health of a commnity, it is possible that the term community health may be more expressive than that of public health. In one of the newer medical schools a department of environmental and community health has been established with a well-known internist as head of the same. It is hoped that similar departments will be established in our leading medical schools.

Certainly the problems of community health should be an essential part of the the training of every physician, dentist, veterinarian, nurse, sanitary engineer, health educator and social worker.

The responsibility of medical care of the sick individual should ever remain within the province of the practicing physician, but the preventive aspects of disease should offer to him an opportunity for useful service equal to that of diagnosis and treatment.

Furthermore, in the broad field of preventive medicine and community health. the practicing physician and public health administrator can meet on common ground, and by sustained leadership and organized effort, attain more readily the ultimate goal of optimum health for the individual and the community.

Some Observations on Gastro-Intestinal Distention

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Gastro-intestinal distention is a condition which has long been recognized as a disturbing feature of a great variety of diseases. During recent years it has been encountered less frequently in surgical patients for several reasons: preoperative and postoperative care of patients is better, gentleness in surgical technique is repeatedly stressed, antibiotics are widely employed in the prevention and treatment of peritonitis, and postoperative distention is avoided by the use of gastroduodenal suction during and following surgery.

This article briefly summarizes pertinent literature and observations by my associates and myself on gastro-intestinal distention[1, 2], with particular reference as to how air enters the gastro-intestinal tract.

The method for the entrance of external air into the stomach is commonly inferred by the term "swallowed air", yet few observations have been made that distended patients swallow excessively. Although it is quite possible that small amounts of swallowed air taken in over several days time may accumulate above a site of obstruction in such quantities as to produce abdominal distention, all physicians have seen cases of rapid gastric or intestinal distention occurring overnight or even in a few minutes, some accurate observations having been made of tremendous dilatation of the stomach occurring in five minutes or less. The conclusion is tenable then that external air can enter the esophagus and stomach in large amounts and very quickly. As to how it occurs, the following are of interest.

Since acute gastric dilatation is customarily a complication of some pre-existing medical or surgical problem and since it has been associated with a great many diseases, it must be brought about through a nervous mechanism. An early theory suggested atony of the stomach as a result of a reflex disturbance of extrinsic gastric innervation, thus allowing the accumulation of gases and fluids which ordinarily would pass on. However, the exceedingly rapid development seen in many instances upsets this idea as a main cause. Duodenal obstruction is a second etiological theory, but it is found in only 20 to 25 per cent of the fatalities due to acute gastric dilatation. A third theory blames an excessive gastric secretion of gas, but this is not believed now, since it has been pretty well shown that the tensions of gas in the alimentary tract tend to approach those of the blood and to obey the laws of physical diffusion. A fourth possibility is that of altered respirations. The importance of abnormal respiratory movements became more apparent as our studies progressed.

Weissgerber[3] credits Kehrer in 1877 with the first suggestion that air could be sucked into the stomach, and the conclusion that such "respiratory sucking" accounted for the free gas in the stomach and intestines of the newborn within 15 minutes after birth. Wyllie[4] in 1895 studied medical students who were able to suck air into the stomach, and by direct laryngoscopic examination was able to see that these students could produce a small opening in the superior esophageal sphincter. This valve is normally closed and keeps us from aspirating air into the esophagus with each breath; but as the upper part of the esophagus has some striated muscle, the sphincter can be consciously opened by many individuals. At least 10 per cent of my students are able to do this trick, which most of them learned as youngsters. The method consists of slightly elevating the chin and extending the neck to pull the larynx forward, at the same time making an inspiratory effort against a closed glottis. The aspirated air is usually belched right back, but some students can form a few words with it. This is actually esophageal speech.

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Esophageal speech can be taught to many individuals who usually through a radical operation for cancer have lost their larynx. The method is the same as for air sucking, the expert being able to retain most of the aspirated air in the upper esophagus and on eructation use it for speaking. The expert is also able to draw the air into the esophagus without visible chin or unusual respiratory movements. The beginner who has not learned such niceties of control often has some of the air pass into the stomach and then complains of distention.

From the preceding paragraphs it is quite apparent that there are mechanisms by which considerable volumes of air can be aspirated into the esophagus and stomach without swallowing. The air sucker has learned the procedure by chance, the esophageal speech patient has been taught the method for a definite purpose, and I believe the so-called "aerophagic" is a nervous, excitable indivdual in whom the process occurs at times without her knowing actually what is going on. We have suspected that some degree of air-sucking or aerophagia takes place unconsciously under many disease conditions and is responsible for many of the flatuosities seen. An attempt was made to approach the problem experimentally.

No constant success was attained in producing acute gastric distention in dogs in spite of carrying out a great many suggestions found in the literature.[1] Using human subjects, however, we are able to show that:

1. Attempting actively to breathe against a closed glottis can produce negative pressures up to 30 cm. of water in the esophagus and stomach, a force easily able to draw down air if the superior esophageal sphincter is open.

2. When the superior esophageal sphincter is intubated with a Levine tube to the lower esophagus, the negative pressures of inspirations will draw down air, in quantities increasing with deeper respirations.

3. When the sphincter is intubated to the stomach, attempting to breathe against a closed glottis can easily draw down 50 to 100 cc. of air with each effort.

4. If the sphincter of an individual who can perform air-sucking is intubated with a Levine tube to the stomach and the subject then sucks in air several times, large volumes of air, 1000 to 2000 cc., can be aspirated back from the stomach.

All these findings are essentially variations of two factors: 1. negative intra-esophageal pressures as a result of inspiratory efforts, and 2. opening of the superior esophageal sphincter. As I have mentioned before, it seems perfectly plausible that as a consequence of a reflex mechanism due to nervousness or apprehension and often associated with a disease or its treatment, these factors could operate to account for rapid accumulations of air in the upper gastro-intestinal tract. Acute gastric dilatation may well be an example of this process.

It has been further observed that frequent belching can be done by many individuals voluntarily and is also a nervous phenomenon common in worried, irritable, distracted, and hyperactive people. Those who belch frequently can only do so if they aspirate air into the upper gastro-intestinal tract, a process essentially the same as air-sucking. A somewhat similar phenomenon found in horses is called "cribbing". In a study of several belchers, we found that they always belch back less gas than they aspirated, and I have seen surgical patients distend post-operatively as a result of nervous belching.

Gastric distention occasionally occurs during an operation, but in general the entrance of appreciable amouts of air is not observed. We have seen distention develop in patients breathing against an obstructed airway and this serious handicap along with the very important one of decreased oxygenation and cyanosis give good reasons why the respiratory passages must be kept clear. In five of our patients receiving curare and cyclopropane anesthesia under slight positive pressure, from 250 to 1700 cc. of gas were removed from the stomach. Positive pressure anesthesia has long been known occasionally to cause gastric distention and we consider this complication more likely under the relaxing effect of curare. It is one of the complications of curare to be looked for and avoided.

For all patients undergoing gastro-intestinal surgery, including cholecystectomies, I have a Wangensteen tube inserted in the operating room right after the sodium pentothal is injected, and continuous suction is started. The gas mask is placed on the patient's face and the inhalation anesthetic then given. The continuous suction empties the stomach of fluid

and air, keeps it empty during the operation, whether gas is aspirated or not, and avoids the serious hazard of vomiting followed by the possible aspiration of vomitus into the lungs. Continued gastroduodenal suction for a day or two prevents postoperative distention and vomiting, and patients consider they have had a fine convalescence. It has been said that the use of the Wangensteen suction procedure has "made abdominal surgery civilized".

In considering the general problem of gastro-intestinal distention, several facts led us to believe that gas passes along the alimentary tract very quickly. Magnusson[5] in 1931 reported that air injected into the stomach displaced barium in the cecum in approximately 10 minutes and reached the anus in 30 minutes. We found by serial roentgenograms that when approximately 1000 cc. of air were allowed to enter the stomach the first part of it reached the cecum in approximately 14.6 minutes, following which the colon filled rapidly. The first flatus was passed in 24 minutes and 970 cc. were collected in an average of 83 minutes.

From these results, which are essentially the same as Magnusson's, it is apparent that when on routine roentgenograms one sees gas in the stomach, small intestines and colon it need not be thought of as originating in each of these organs, as from diffusion or fermentation, but as external air that came down the esophagus a relatively short time before and rapidly passed along the tract. This quick progress can easily account for the high concentration (70-80%) of nitrogen found in analyses of intestinal gas.

The frequent occurrence of increased gas in the gastro-intestinal tract during pyelography offered an excellent opportunity to study a rapid accumulation of gas in patients. Some other interesting theories have been evolved to account for its presence. Oppenheimer[6] believed that the intestines became atonic as a result of inhibitory reflexes arising from renal or biliary colic or the instrumentation of retrograde pyelography, and that with the dilatation of the atonic bowel the small amount of gas always present in the intestines quickly expanded to fill the new lumen. Begg[7], writing on intestinal distention and its urological application, did not believe that distention was due to air swallowed during and after the operation, but that the gas was derived from the blood by intestinal respiration, and that any factor reducing the tonus of the bowel increased the potential capacity of the bowel lumen and permitted the inflow of gas. He cited as a substantiation the marked increase in intestinal gas when a ureteral catheter was passed, and the quick influx of gas into the bowel following the injection of Uroselectan.

To prove our idea that the source was external air coming down the esophagus, we studied 19 patients undergoing intravenous and retrograde pyelography by instituting continuous gastric suction during the time of this examination. We found essentially that if the suction worked continuously and removed all the air from the stomach, from 45 to 1345 cc. for our patients, then there was no increase in intestinal gas from the first to the last pyelogram. As further proof, the composition of the gas aspirated from the stomach was basically that of external air.

An extremely important observation was that three times as much air was aspirated from the stomachs of the nervous patients as from the calm ones. Ordinary swallowing movements were infrequent and did not account for much of the ingested air. In individual experiments we noted that more gas was aspirated during periods of deeper, irregular respirations, when the patient was distressed by some part of the procedure, and that nervous patients were more easily distressed and had longer periods of deep breathing than the calm ones. The factors responsible for the apprehension or distress and the accompanying deeper breathing were intravenous injections, systemic reactions to the injected material, the passage of the cystoscope and ureteral catheters, the introduction of fluid into the renal pelves, and the discomfort of the lower abdominal pressure pad. This finding that nervous reaction is an important indirect element in meteorism during pyelography is in accord with the opinion that other forms of flatulence are often a nervous reflex manifestation.

With these findings it is easy to understand why the preparation of patients for pyelography by enemas and cathartics has not been too successful. The obscuring air is often ingested shortly before or during the procedure and no form of prior cleansing will suffice. It is a bit too drastic to use continuous gastric suction during every pyelography, but sedatives to allay

fear and apprehension are suggested as a part of the preliminary routine.

SUMMARY AND CONCLUSIONS

All observations support the opinion that external air is the chief source of the gas in gastro-intestinal distention. Ordinary swallowing will take down small amounts of air which with time and some obstruction may produce distention. But large amounts of air can also be inspired into the esophagus voluntarily by individuals able to do air-sucking and by esophageal speech patients, and involuntarily by the nervous aerophagics. This air can travel from the stomach to the cecum in 10 to 15 minutes and be passed as flatus in 30 minutes. It was found that inspiration of air accounted for the increased intestinal gas observed during pyelography, and respiratory changes as a result of nervousness, apprehension and distress seemed to be the factor responsible for the air coming down the esophagus. We know that increases in the respiratory rate and depth considerably change intra-esophageal negative pressure, and we suspect the nervous reflex mechanism may also alter the superior esophageal sphincter tone or action so that a small amount of air is aspirated into the esophagus with each breath. At a rate of 20 breaths a minute it would not take long for a considerable volume of air to enter the esophagus and stomach.

It appears to us that under a variety of stresses, such as during a pyelography, following an injury or accident, or during a postoperative period, some patients, particularly the nervous and apprehensive ones, become "temporory aerophagics" of varying degree. Such a process offers a good explanation for acute gastric dilatation, which has been associated with so wide a variety of conditions that it must be brought about by a reflex nervous mechanism. One can conceive of the stimulus arising from mental agitation alone, or from the distress of a diseased or injured organ or tissue. Renal colic and gallbladder disease are notoriously associated with distention. Gas usually accumulates quickly when intestinal obstruction is present, but the nervous factor must even here play a part, because we have seen strangulated obstruction present for three days with very little gas in the loops above the involved bowel.

Physicians have long observed that the nervous, apprehensive patient frequently gets into trouble postoperatively: cannot void, cannot rest, complains inordinately of pain, and grunts and groans and huffs and puffs and becomes distended. Since prevention of the latter is better than treatment, the quick employment of continuous Wangensteen suction will keep the stomach free of offending air. I have often thought that *mild* sedation is not used often enough in the immediate postoperative period to allay undue anxiety. Its outstanding value is apparent in dealing with hyperthyroidism, but other patients will be equally benefited by a toning down of their whole reaction, and the need for narcotics will be lessened.

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Has Sympathectomy Kept Its Promise in the Treatment of Essential Hypertension?

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Dr. de Takats: The title of my talk, "Has Sympathectomy Kept Its Promise?" clearly implies that we did make promises. In order to answer the question in the title, we must evaluate our results. Enough time now seems to have elapsed to allow us to reach certain conclusions.

Before 1940, we had done quite a few sympathectomies of limited extent, usually subdiaphragmatic, with only very variable and moderate success, and were becoming a bit discouraged with the method. In 1940, however, two significant things happened. In the first place, Dr. Robert W. Keeton suggested that we begin a cooperative program for studying these patients before and after the operation, in a manner similar to that done by Dr. Max Peet at the University of Michigan. The second significant thing was that Dr. Reginald Smithwick, of Boston, published a paper which stated that none of the previous sympathectomies for hypertension had been extensive enough, with the corollary that patients who had failed to show significant improvement by earlier operation could be reoperated upon and their sympathectomies extended. In order to study this point, we called back fifteen of our early patients and reoperated them according to Dr. Smithwick's technique, with very good success. This stimulated us to continue the program and to broaden it to its present extent.

Since 1940, at least one aspect of the surgical treatment of hypertension by sympathectomy has become standardized. We all do about the same operation, and it is a total splanchnicectomy according to the Smithwick technique. Where there seems to be a clinical failure, one of the first questions we ask ourselves is: Was the sympathectomy adequate? It is possible to check these patients for adequacy by testing for sweating that occurs in the cutaneous segments which supposedly have been sympathectomized.

In the selection of patients for sympathectomy we were led inevitably to a study of the natural history of essential hypertension in order to select those patients for whom operation is most likely to be helpful. Our concept of essential hypertension is that it is a progressive disease. Nobody is very sure of what the natural history of untreated hypertension is, and a mass population survey would be very interesting and very valuable, if the study could be done carefully enough over a long enough period of time to let us know what the prognosis of untreated hypertension really is.

We feel that essential hypertension is a disease which first manifests itself by vascular instability. Children who show most reaction to vascular stimuli such as the cold pressor test are those who are most likely later on to develop the full-blown picture of hypertension. From this early vascular reactivity associated with normal blood pressure, one may pass to the stage of adolescent hypertension. This is a rather interesting period, since very often patients in their early teens may show a hypertension which later disappears completely, never to reappear. We have been much impressed by two patients who, at the age of 15 or 16, showed sustained hypertension at high

blood pressure levels but who, after periods of 5 or 6 years, were found to be completely normal. For this reason we do not feel that we are justified in operating upon patients in this age group with high blood pressure. However, from the stage of adolescent hypertension, one may pass on to the stage of intermittent hypertension. We define this as the type of hypertension existing in people who, when up and about, run diastolic blood pressures above 100 mm Hg. However, when these patients are put to bed for forty-eight hours or given large doses of sodium amytal, their blood pressures fall toward normal. In most patients of this group organic damage is minimal. However, there is a small but important group within this larger group of patients with intermittent hypertension who show vascular damage. There may be hemorrhages in the eyegrounds, evidence of coronary artery disease, cerebrovascular accidents, or mild renal disease. We feel — and this is a controversial point — that patients with intermittent hypertension who also show evidence of vascular damage should be operated upon. We do not consider patients with intermittent hypertension who show no evidence of vascular damage to be operable. Our clinical experience convinces us that once vascular damage makes itself evident in this group, operation is necessary because these patients have a much poorer prognosis than patients who have intermittent hypertension without any evidence of vascular damage.

From intermittent hypertension we pass to the stage of continuous hypertension, where bed rest, amytal, and other methods of sedation cannot reduce the diastolic pressures to normal. Some patients may have continuous hypertension for years without showing very marked evidence of vascular damage. However, continuous hypertension passes on, in many cases, to the stage of "malignant hypertension". Now, exactly what malignant hypertension is, is a subject of controversy, since definitions differ, and this is one reason why surgical statistics on the salvageability of patients with malignant hypertension differ so much, because the surgeons are often talking of different types of patients. We separate this category into two groups, the "premalignant stage" where there is papilloedema and a high diastolic pressure, without renal damage, and the true "malignant stage" where there is papilloedema with a high diastolic pressure and evidence of severe renal disturbance. We feel that patients in the premalignant stage often can be helped by surgery. When renal damage has become severe, however, the patient has passed beyond the stage where operation can help him.

In the etiology of essential hypertension there are two chief components, both of which operate in every case in variable proportions: the neurogenic mechanism and the humoral mechanism. In the humoral mechanism we include both renal factors and endocrine factors which may originate from the pituitary-adrenal cortical axis. The patients who are predominantly neurogenic hypertensives are the group whom we are able to help by sympathectomy.

The question then comes up: How, in our preoperative study, can we differentiate the patients with the predominantly neurogenic hypertension from those with predominantly humoral hypertension? One method is to attempt to use a drug such as tetraethyl ammonium chloride, which blocks the nerve impulse at the autonomic ganglia. We give this drug and observe how low the blood pressure falls. This is the so-called TEAC "Floor", as Eugene Ferris, of Cincinnati, calls it. If a patient has a diastolic blood pressure which falls to about 80 mm Hg after TEAC, it is reasonable to assume that his hypertension is largely on a neurogenic basis.

Another way to approach this question is to attempt to stimulate the neurogenic element to see what happens to the blood pressure. The cold pressor test is a very useful test, since it provides a painful neurogenic stimulus, and patients with neurogenic hypertension should have a much higher rise in blood pressure following the cold pressor test than patients with predominantly humoral hypertension. However, it is important to remember that there are two elements in the cold pressor test — an immediate neurogenic element and a later humoral element. We can demonstrate this by giving TEAC during the cold pressor test. There is no immediate rise in blood pressure because the neurogenic mechanism has been blocked. However, after a time there is a delayed rise in blood pressure which does not respond to TEAC. What seems to happen is that the cold pressor test stimulates the pituitary, perhaps through the release of adrenalin, leading to stimulation of the adrenal cortex, thus resulting in humoral hypertension. This is significant since it points up the fact

that there is no such thing as pure neurogenic hypertension or pure humoral hypertension, but in each case there is a mixture of both factors in varying proportions. What we must do preoperatively is to decide what proportions exist in each case.

I should like to emphasize the point that every time the patient is subjected to a severe neurogenic stimulus, there may be release of epinephrine with stimulation of the pituitary-adrenal cortical axis. This is the common meeting ground between the neurogenic and the humoral elements in every case of hypertension. The adrenal cortex may well be involved in every patient with essential hypertension. It may be that when the neurogenic element has started the hypertension, the disease may so progress that after a time the only way to help the patient would be to attack the adrenal directly by surgery.

To summarize our criteria for operability, we recognize three indications for surgical treatment of essential hypertension:

GROUP (1): We feel that patients with intermittent hypertension who show clear evidence of vascular damage should be operated upon.

GROUP (2): We operate on patients who show rising diastolic pressure during middle age.

GROUP (3): We operate on patients who show rapidly progressive, pre-malignant hypertension, who have adequate renal function. We do not operate on patients with poor renal function.

Most internists will agree with us on the second and third groups, but whether or not patients with intermittent hypertension with early vascular damage should be operated upon is still a controversial point.

Once we have operated these patients, we must decide upon some way of following the patients and assessing the success or failure of our operation. Earlier groups have attempted to divide the patients into four groups, according to the Keith-Wagener-Barker classification based on eyegrounds. These groups are followed by comparing longevity alone in surgical cases compared to the survival of similar, non-operated patients. This method shows trends but does not help in assessing the individual patient's prognosis. After all, survival alone is not too good an indication of success. A patient after operation may develop several cerebrovascular accidents and live from ten to twenty years as a helpless invalid. This we could not consider a successful result, even though survival is lengthened. We must look for a more individual method of following up our patients. Again let me emphasize that followup is done at our clinic by the same group of specialists who followed the patient preoperatively and decided upon operation.

Our first premise is that we cannot judge the success or failure of the operation by the fall in blood pressure alone. The patient may have a drop in blood pressure but may later develop a coronary occlusion or a cerebrovascular accident. On the other hand, the patient may continue to have a high blood pressure but may be completely rehabilitated economically. Severe incapacitating headaches may disappear and the patient may be able to go back to work and lead a useful life, even though the blood pressure remains high.

After operation, we repeat the tests we have done prior to operation to see if we have overcome the patient's vascular reactivity. What happens to the patient's vascular reactivity when a standard stimulus, such as cold, adrenalin, CO_2 inhalation, or the Valsalva maneuver is applied after operation? Many of our patients have shown a marked difference in response after the operation, to the same stimulus. Many patients who continue to show high blood pressure after operation no longer over-react to cold and stress the way they did prior to the operation. This may be a very valuable contribution to their welfare. The Valsalva maneuver is a very easy thing to do, and we have used it quite freely prior to operation and after operation as a physiologic stimulus, and feel that blood pressure rise following the Valsalva maneuver may turn out to be one of the most useful tests of vascular reactivity.

To overcome criticisms of statistics based on the drop in blood pressure alone or on survival alone, we decided to divide our cases into two groups: those in which we have had worthwhile" results and whose results have not been "worthwhile". What we consider "worthwhile results" depends upon the group within which the patient fell prior to operation. In Group (1), the patients with intermittent hypertension

with early vascular damage, the results are worthwhile if the blood pressure falls to normal after operation and the patient is restored to full working ability. In Group (2), the middle-aged hypertensives with rising diastolic pressures, the results are worthwhile if the diastolic blood pressure becomes lower or stabilized, and there is regression of vascular damage. The patient again must have full working ability for the results to be judged worthwhile. In Group (3), the patients with pre-malignant or malignant hypertension with adequate renal function, we consider a worthwhile result to consist of arrest of the disease with regression of papilloedema and relief of symptoms, especially relief of the severe and disabling headaches which these patients often have. These patients must show at least restricted working ability for the results to be considered worthwhile. On the other hand, we consider any operative result not to be worthwhile if there is a rise in the diastolic pressure after operation, increasing vascular damage, no symptomatic relief, or death or invalidism within five years. Admittedly, these criteria are rather crude, but they are clinical, and seem to be better than statistical analyses based on blood pressures alone or on survival rates.

To come back to the original question posed in the title of this seminar — Have we kept our promise with sympathectomy? — In order to answer this, I am going to show you the results of a group of 55 patients operated upon by me in 1946. I should like to emphasize that these patients were operated upon by one surgeon (myself) in the same hospital (St. Luke's Hospital), using the same technique, with the same preoperative criteria for operation and the same post-operative followup examinations. Hence, this group is as standard as a clinical group can be. These patients all had five years of careful postoperative study.

Group	*Number*	*Worthwhile*	*Not Worthwhile*
(1)	15	12	3
(2)	31	17	14
(3)	9	4	5
	55	33	22

When we consider these results, we see that patients from Group (1) seem to have done well after sympathectomy. We are quite satisfied with the salvage of 4 patients in Group (3). Anything at all we can do for patients in Group (3) is a positive achievement. However, we showed only a little more than 50% success in Group (2), and this is what we are working on at present. Can we develop better criteria for operation for patients in Group (2) so that we will have a smaller percentage of failures? In analyzing why results with some patients in Group (2) were unsuccessful, we have developed certain additional criteria of operability. We have come to feel that patients who show too much impairment of renal function should not be operated upon. We now insist upon at least 15% PSP excretion within the first 15 minutes, and prefer that the patients show at least 20% PSP excretion within 15 minutes. We insist upon a minimum urinary concentration to 1.018 overnight, and prefer that patients concentrate to 1.020. They should reconcentrate urine in a 6 hour water tolerance test. A second group which does not respond — at least to sympathectomies alone — are patients who seem to show excessive adrenal cortical secretion. We are not as yet ready to define this group, except to say that they do not have full-blown Cushing's disease, but are not primarily "neurogenic" hypertensives.

Dr. George E. Wakerlin, Professor of Physiology, University of Illinois: In discussing sympathectomies for hypertension, Dr. de Takats and I have been friendly enemies for many years. In commenting upon his views on the case for sympathectomy in the treatment of hypertension, it is interesting to note that sympathectomy upon the normal dog has no significant, lasting effect on blood pressure. With sympathectomy upon normotensive human beings, the results are the same. Moreover, the fact that we cannot help experimental renal hypertension by sympathectomy does not necessarily mean that the operation is not of some value in human hypertension, since there is yet no definite proof that essential hypertension in the human is the same disease as experimental renal hypertension in the dog.

I agree with Dr. de Takats regarding the three probable pathogenetic mechanisms in essential hypertension. For the present, we may consider the pathogenesis of the disease to be analogous to a tripod, the legs of which are a neurogenic factor, an endocrine factor involving the anterior pituitary-adrenal cortex axis, and a

renal factor. Counteraction of one leg, as by sympathectomy, may conceivably alter the other two legs of the tripod. Until we know more about the pathogenesis and pathophysiology of essential hypertension, our treatment must necessarily be empirical. If the therapy works empirically, we should use it.

My views in the past ten years have changed relative to sympathectomy for essential hypertension. When surgeons first began doing sympathectomies, I was skeptical. I was skeptical because many of the early claims were exaggerated and inadequately controlled and some of the surgeons — at this point I want to make it clear that I do not include Dr. de Takats among these surgeons — had an inadequate understanding of the physiological mechanisms involved. However, I now feel that perhaps 10% of patients with essential hypertension may obtain what is tantamount to a cure following surgical sympathectomy so far as their blood pressure, progressive vascular damage, symptoms and signs are concerned. An important problem in this connection is to devise more satisfactory methods for distinguishing the 10% who are going to be definitely benefited by the operation from the 90% who are going to be helped less or not at all. Actually, my figure of 10% may be somewhat low because some of the patients who are not "cured" show symptomatic relief and possibly lengthening of life. I agree with Dr. de Takats' point that even though he may not show decline in blood pressure, the patient may be benefited because he shows less vascular hyperreactivity to pressor stimuli, and this may be of importance on a long term basis.

Parenthetically, I should like to say that the term "essential hypertension" should be replaced. After all, the high blood pressure is only a sign of the disease, and I would prefer to have it called "hypertensive vascular disease", to emphasize the basic pathophysiological mechanism. In closing, I agree with Dr. de Takats' criteria for malignant hypertension.

Dr. Ford K. Hick, Professor of Medicine, University of Illinois: I find it rather difficult to assess the results in essential hypertension. In my own office practice I have given up the medical treatment of essential hypertension, save by reducing the obese. I don't think there is very much we can do medically. However, on the other hand, it might be that the disease is not so bad. After all, women can carry high blood pressure for many years with much less danger than men can. When I was a medical student in 1927 we were told that patients who had a diastolic blood pressure of 120 mm Hg would be dead within two years. We know today that this is nonsense. I have seen a female patient with a blood pressure of 260/170 who got along very well for over 10 years. I agree with Dr. de Takats that blood pressure is not the criterion for the severity of this disease. I agree with Dr. Wakerlin that we should consider this, rather, hypertensive vascular disease. However, this raises the point that many surgeons will not operate on patients with hypertension who do show evidence of vascular disease, that is, on the patients with the coronary occlusions and the cerebral vascular accidents, who seem to me to need the operation most. Did I understand you to say, Dr. de Takats, that you will operate on a patient who has recovered from a coronary occlusion?

Dr. de Takats: That's right.

Dr. Hick: I am reluctant to recommend surgery on patients with early hypertension because it is very difficult for me to tell which patients are going to do well and which patients are going to do poorly. I prefer to observe the patient until I have made up my mind as to how they will get along before recommending operation. However, I must say that I have nothing better to offer. I should like to make the point that there is some danger of lowering the blood pressure in elderly patients with vascular disease. After all, if we lower the cerebral, coronary, and renal blood flows by lowering the pressure, we may do more damage than good. Dr. de Takats' view on the possibility of operating upon the adrenal glands is interesting, and we might consider establishing a group to study the influence of the adrenal gland upon hypertension, both clinically and physiologically here at the University of Illinois. I agree with him that teamwork between the internist, the surgeon, and the psychiatrist is necessary for appraisal.

The Ambulatory Treatment of Retinal Vascular Disease

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In the treatment of certain conditions of the aged, there is an overlapping of the special fields of medicine. This is no more frequently seen than in the retinal vascular diseases which Friedenwald[1] has classified as: (1) Senescence, (2) Atherosclerosis, (3) Hypertensive arteriolar sclerotic processes, (4) Diabetic retinitis.

In the care of these conditions, there must be a rapprochement of the fields of ophthalmology and internal medicine, but until the fundamental ocular pathology is understood by both groups, this is difficult if not impossible and the patient will suffer.

In these conditions the eye is a mirror of a general condition. We can see vascular pathological changes from their inception to their termination. These pathological changes become more evident here, since we are dealing with a paper-thin membrane possessing a terminal blood supply. Other organs of the body suffer simultaneously, but because of large tissue reserve and an anastomosing blood supply, function is preserved.

Earliest vascular lesions in the fundus indicate a widespread altered physiology and as our knowledge and understanding of physiology increases, therapeusis will be more and more directed toward re-establishment of normal physiology at the earliest possible date (Dugan[2]). It is at this time that the ophthalmologist and internist can obtain dramatic results if we consider the hopeless prognosis usually given these patients.

While research continues on the etiology of vascular disease, we are faced with a growing problem of blindness. Until we can prevent vascular disease, the problem resolves itself into an attempt to prevent its complications.

Early vascular disease is characterized by vascular spasm which may be localized or general. As the condition progresses an anoxia of the blood vessel wall results. As this anoxia increases, pathological lesions appear in the intima and media. The effect of spasm and pathological changes in the wall is a narrowing of the lumen which results in resistance to blood flow. This narrowing may be accompanied by venous constriction where the artery crosses the vein. There may be an endothelial proliferation up and down stream at this point. Leopold[3] has shown there is a definite direct relationship between cerebrovascular resistance to blood flow and the grade of hypertensive retinopathy. As the lumen is reduced in size, there is a slowing of the blood stream, resulting in an attendant anoxia of the blood vessel wall. Local areas may be damaged sufficiently to permit serum, white blood cells and red blood cells to pass through into the adjacent tissue. The result will be exudative lesions or flame-shaped hemorrhages. As the integrity of the wall is further damaged, we may see pre-retinal hemorrhages or even hemorrhages into the vitreous. If there is a break in the blood vessel wall, the eye will be lost since 1-2 cc. of blood escaping into the eye will result in absolute glaucoma.

With the slowing of the blood stream, sludging of the blood occurs. Knisely Block and Elliot[4] — Knisely Block[5]. Small clumps of agglutinated red blood cells behave as miniature thrombi blocking arterioles and venules too narrow to permit passage over masses of cells which are sticky and lacking in repellent force. These by accretion may attain dangerous proportion by packing together and forming true thrombi. Endothelial lesions secondary to vascular wall pathology hasten thrombus formation.

Retinal vascular disease is, as a rule, slowly progressive. However, it may attack one vascular system earlier than others.

Senescence is an example of this. The earliest changes are found in the choroidal capillaries which are fibrosed and hyalinized.

Retinal vascular disease may have acute

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exacerbations especially those associated with vascular spasm. Spasm of the retinal arteries and arterioles has frequently been directly observed with the ophthalmoscope, Duke Elder[6], Rexed[7]. Krough (Evans)[8] has reported definite capillary sphincters at the junction of the capillary and the vessels of the next higher order. The resultant pathology from spasm is quantitative and dependent on the the degree, the site and duration of the spasm.

If spasm occurs in the artery, arteriole or proximal segment of the capillary, an ischemia results. If spasm occurs in the distal segment of the capillary bed a congestion occurs. In either instance, a capillary wall anoxia results and any one of three stages may follow depending on the duration of the spasm and the content of the blood vessel. These three stages are: (1) Peristasis in which the fluid elements of the blood escape into the surrounding tissues, (2) Leukostasis in which white blood cells are permitted to pass through the vessel wall, (3) Rubrostasis in which red blood cells pass by diapedesis into the adjacent tissue (Dugan[9]).

Associated conditions frequently seen are anemia, nutritional deficiencies, metabolic disorders, increased capillary fragility, hypertension, cardiovascular renal disease and diabetes. Each associated condition must be adequately cared for. Unfortunately, the retinal vascualr disease continues and eventually ends in blindness unless a severe vascular lesion elsewhere in the body terminates the case. Dolgar[10] reports that in 200 diabetics followed 25 years not one has escaped retinal vascular disease regardless of age of onset, severity of the diabetes or type of treatment received. Retinal vascular lesions presage progressive visual deterioration, Friedenwald[11] confirms this. He feels diabetic retinitis is related much more closely to the duration of the diabetes than to its severity. Since diabetic patients under modern care live longer, the frequency of this complication is increasing.

In evaluating patients for therapy full cooperation of the ophthalmologist and internist is essential. The ophthalmologist can state with reasonable certainty whether a patient can expect favorable, doubtful or disappointing postoperative results from a sympathectomy. Once organic lesions of the blood vessel set in, sympathectomy loses its value in direct proportion to the pathology (Bedell[12]).

Once organic changes occur in the blood vessel wall, the pupils should be dilated and the fundus examined at each periodic physical check-up. Petechial "hemorrhages" so called because they were thought to be hemorrhages from the capillaries in diabetics are now known to be aneurysms at the link between the deep and superficial capillary plexus, [13, 14]. They precede severe retinal vascular disease. Flame-shaped hemorrhages result from a diapedesis of red blood cells through local anoxic areas in the blood vessel wall. If this anoxia becomes more acute, pre-retinal or vitreous hemorrhages result. It has been our observation that under therapy flamed-shaped hemorrhages absorb within one to two weeks. Where pre-retinal hemorrhages are present, if they measure more than 3-4 disc diameters in width, absorption is not rapid enough to prevent the toxic effect of the blood from damaging the underlying retina. Vitreous hemorrhage represents an advanced stage of vascular damage. If from a single localized vessel anoxia, it may be successfully treated with a combination of dicumarol and foreign protein. However, if there is associated pre-retinal hemorrhages retinal damage and visual loss will be proportional to the volume of pre-retinal blood and the proximity to the macula. Klein[15] has made the greatest single contribution on treatment of retinal vascular disease. In writing on the prevention of retinal venous occlusion, she discusses in this very comprehensive paper the mechanism of thrombosis, and gives the subjective and objective findings that precede thrombus formation. Anyone caring for patients with vascular diseases should study this article.

She states advancing obliterating sclerosis alone results in occlusion in which anticoagulant therapy does not help since thrombus formation is a terminal step. In these cases sufficient delay of this final event, to permit collateral circulation if at all feasible, holds the only promise for preservation of vision. This can only be accomplished by anticoagulant therapy.

Once thrombus formation has occurred or arterial occlusion has occurred all efforts should be made to restore the blood flow in the vessel. Present therapy gives gratifying results if initiated within the first few hours after occlusion.

In treating vascular diseases of the retina, dicumarol, rutin and cevitamic acid appear to

have desirable therapeutic properties. There is considerable proof to support the belief that dicumarol is a vasodilator (Gilbert[16]). It causes a hypoprothrombinemia, tends to restore the repellent force of red blood cells and decrease agglutination and adhesiveness of blood platelets. It prevents thrombus formation and propagation of a thrombus. DeTakats[17] states that heparin has more desirable features since it has an antithromboplastin, antiprothrombin and antithrombin factor, but when we consider that dicumarol can be given safely to ambulatory patients (Wright[18]) and has been proved to be effective in retinal vascular disease (McLean[19], Klein[20]), it is at present the best anticoagulant available in prevention of complications of the diseases under consideration.

Vitamin P, while it favorably influences increased capillary fragility, does not prevent or resolve retinal hemorrhages. It is, however, necessary for a normal vascular permeability. Cevitamic acid maintains a normal state of the intercellular ground substance in which the cells are imbedded and cemented together.

In treating vascular diseases of the retina, we hope to accomplish these things. By increasing the repellent force of the red blood cells and decreasing the agglutination and adhesiveness of the platelets, we hope to increase the fluid state of the blood to relieve the anoxia of the blood vessel wall. Attempting to maintain the normal permeability and normal structural state of the blood vessel will aid in preventing further loss of blood from the vessel and permit better nourishment of the retinal tissues. Absorption of hemorrhages of retinal or pre-retinal nature at the earliest possible date and at a more rapid rate decreases the residual retinal pathology. Early retinal vascular disease can be controlled by proper dicumarol therapy. The prognosis is poorer as the vascular disease progresses and may be irrepairable. It is essential that these patients remain on dicumarol continuously. Each patient that stopped dicumarol had an exacerbation of the retinal vascular disease in from 48 hours to six weeks.

Before dicumarol can be administered, a prothrombin concentration percentage determination must be done and repeated daily since individuals react in varying degrees to similar doses of dicumarol. This necessitates hospitalization.

Furthermore, the drug has its full effect 48 hours following administration. (Heparin is used to initiate treatment in vascular occlusion because of its more rapid action.) Initial doses of dicumarol range from 200 to 300 milligrams. Daily prothrombin per cent concentrations are done and plotted until a constant level between 20-30 per cent concentration is maintained. Maintenance doses usually are 50-100 mgm. three to seven times per week. Few patients cannot be adequately regulated in two to three weeks. Once released from the hospital, the patient should have a prothrombin check done weekly, then every two to three weeks. It is advisable to have the same laboratory check the blood.

There have been 23 deaths from hemorrhagic diathesis in patients receiving Dicumarol reported in the literature, but on reviewing these one finds that 63 per cent of these had subacute bacterial endocarditis and the remainder had massive doses of dicumarol without benefit of laboratory work. In those cases where blood was taken in the terminal stage, the prothrombin concentration per cent was below 10 (Duff Skull[21]). Contraindications to administration of dicumarol are pregnancy, hepatic lesions, ulcerative lesions of the G.I. tract, purpura blood dyscrasias, subacute bacterial endocarditis, recent brain and spinal cord surgery. The most definite contraindication is inadequate laboratory facilities to check the prothrombin concentration per cent. Where petechial hemorrhages and hematuria occur the patient should have the dicumarol stopped. Synthetic vitamin K administered in large doses and fresh blood transfusions given.

Page and Corcoran[22] using pyogens were able to obtain marked improvement in patients with advanced hypertension retinopathy. They felt this response was through the adrenal cortex, plasma and tissue enzyme systems, and body metabolism. Typhoid gives a similar response. When combined with dicumarol, small doses of typhoid seem to enhance the effect of the dicumarol.

Twenty-three cases of retinal vascular disease have been maintained on dicumarol for from five to thirty months. While time does not permit a review of these patients' histories, 14 have maintained vision and the retinal lesions have not advanced during 6 to 30 months of ambulatory dicumarol therapy. These 14 consist of

two cases of retinal senescence, 5 cases of hypertensive arteriolar proceses, 1 central vascular occlusion, seen 5 hours after the first symptoms, and 6 diabetics seen within one week to three months after visual symptoms occurred.

One complication, that of hematuria, occurred in a hypertensive who had regained visual acuity and who had been controlled five months but was not listed above in the controlled group since six weeks after stopping dicumarol she developed a vitreous hemorrhage in one eye.

One central venous occlusion seen after one week did not respond to therapy.

Seven diabetics received no permanent benefit from dicumarol therapy. Visual impairment had lasted from 9 months to 2 years prior to therapy.

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Subdeltoid Bursitis

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Subdeltoid bursitis or subacromial bursitis is an inflammatory process affecting the bursa lying between the under surface of the deltoid muscle and the outer surface of the joint capsule. Inflammation of this bursa is one of the most common causes of stiff and painful shoulders, occurring in from 65% to 75% of all cases of shoulder pathology. This condition was accurately described by an English anatomist, J. S. Smith, in 1834. Although many worthwhile contributions were made from this time on, it was not until Dr. Codman published his book on *The Shoulder* in 1934 that a major treatise appeared.

Anatomy.—The subacromial bursa is one of the largest in the body. (Figure 1) It is a synovial sac approximately 1½ inches in diameter, though it may be as large as the hand. This bursa acts as a cushion between the deltoid muscle and the acromium process above, and the joint capsule below. From the clinical standpoint it is considered as one structure, but anatomically it consists of three bursa. These three compartments often communicate with each other, but may be separated by thin, filmlike septa. The bursa normally do not communicate with the joint. The roof of the bursa is attached above to the undersurface of the acromium and below to the inner surface of the deltoid muscle. It encircles about one-half the

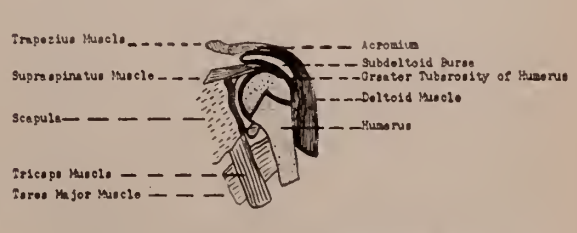


Figure 1. Anatomy of Subdeltoid Bursa.

From the Dept. of Surgery, Graduate School of Medicine, University of Pennsylvania.

Read before the Surgical Section at the Graduate Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania, Feb. 9, 1951.

circumference of the humerus. The roof is so fused and adherent to these structures that with few exceptions no accurate separation can be made on dissection without damage to the roof of the bursa. The floor of the bursa is attached by its undersurface to the humerus, the joint capsule, the biceps sheath, and the short rotator muscles, i.e., the infra and supra-spinatus muscles, the teres minor and the subscapularis. The floor also, cannot without great difficulty, be dissected off these flattened and often fused structures. Normally the roof and the floor of the bursa are in contact, lubricated by a very small amount of fluid, possibly secreted by the endothelial cells lining the bursa. A fine thin layer of blood vessels and lymphatics lies below these lining cells.

Pathology.—Under abnormal conditions the subdeltoid bursa may become inflammed and distended with fluid; it's walls may become adherent, or it may contain calcium deposits within its lumen. When it is of long standing, the wall may undergo great thickening, becoming covered with fibrous ridges, septa and tags, so, that in appearance somewhat resembles the interior of a joint the seat of chronic arthritis. The tags may become detached and form melon seed bodies which can be detected on palpation. Occasionally the thickening is so great that the cavity is almost obliterated and the bursa becomes converted into a solid mass.

Subdeltoid bursitis is rarely primary, usually resulting from lesions in contiguous tissues, particularly following damage to the supraspinatus tendon. This tendon works at a greater mechanical disadvantage than do the other short rotators, and thus the strain on it's fibers is most severe, causing rupture of fibers, minute hemorrhages, hematoma formation and calcification. It is also possible that metabolic or infectious processes are a factor in the pathology produced. So there is a weakening of the tendon structures and the calcareous deposits may rupture into the bursal sac. The stimulation of the well enervated bursal walls results in pain, plus cellular proliferation and fluid secretion. The sac becomes distended with fluid, further increasing the pain due to pressure. With the proliferation of fibroblasts and gradual thickening of the bursal sac, fluid is also gradually absorbed and pressure and pain is lessened. Because of this thickening and fibrosis, however, there is resultant less movement of the part.

When a patient with an acutely painful shoulder due to calcification is operated on and the floor of the subacromial bursa is exposed, a small ring of hyperemia indicates the site of calcification. On incision into this area, a soft pasty, yellowish-white mass is extruded. Often it has the consistency of tooth paste and appears to have been held in the area under considerable tension. When the symptoms have been less acute and such an area is exposed, the calcareous material is seen as dense, gritty masses or placques. On microscopic examination, a mass of round or ovoid bodies, ranging in size from that of bacteria to masses 10 to 15 times the size of white blood cells is seen. The bodies are whitish and translucent and appear to be elastic. Their composition varies, but most often they are mixtures of calcium phosphate, calcium oxalate, and organic matter. Pathologically there has not been evident, in but rare exceptions, either an infectious focus or any alteration of normal metabolic processes.

Incidence.—Subdeltoid bursitis affects both sexes, the males being affected mainly in young adult life and in mid-life, and the women showing a preponderance of bursitis at an older age. This might be expected since athletes in their early twenties and workers in trades and occupations requiring strong exertion with the arm in abduction are frequently affected. In the older age groups the females have the highest incidence. Bosworth found calcium deposits about the shoulder without symptoms in 33% of some 6,000 non-selected patients whom he x-rayed.

Etiology.—It is most likely that acute or chronic trauma is the main cause of subdeltoid bursitis. This occurs from twists or forcible abduction motions of the upper arm, as well as from direct violence. Presumably this bursa could become inflammed through infection or the ill-defined toxic or arthritic factor. Trauma may result from overuse of the shoulder, irritation due to occupational maneuvers (such as typewriting where the arms are held slightly abducted for long periods) or falls on the outstretched hand or shoulder itself. In elderly individuals, there is found, especially in those who have done laboring work for many years, a degeneration of the tendons of the short rotator muscles. Under such conditions mild trauma may produce injury or rupture of these tendons.

Subdeltoid bursitis has also been described frequently in patients with an acute upper respiratory infection, acute paranasal sinusitis, and apical dental abscess. A few investigators believe that focal and glandular dysfunction are more important than trauma, etiologically. Voight reported a large series of women with painful stiffening of the shoulder at the menopause. These women were actively engaged as typists, pianists or teachers, using their arms a great deal. Subdeltoid bursitis is common among diabetics, and it is thought that hypo and hyperthyroidism may be related to the etiology of this condition. Inasmuch as the majority of patients with subdeltoid bursitis are over 40 years of age, they fall into that group where focal infection is prevalent. Lesions here are probably produced by a combination of trauma (acute and sudden or oft repeated and slight), and the physiologic change of age in older patients.

Signs, Symptoms and Diagnosis.—In acute traumatic subdeltoid bursitis findings are invariably definite and striking. The patient complains of severe shoulder pain and declines to move the arm which is held rigidly at the side. He cannot raise the arm laterally, even passive motion causing severe pain. The arm may be passively elevated in the sagittal plane by 30-60 degrees, but close inspection reveals motion to occur by rotation of the scapula on the chest rather than at the scapulo-humeral joint. Palpable swelling and fluctuation may be present, but always there is acute diffuse tenderness just below and anterior to the acromium. The patient is unable to reach backwards into a rear pocket or overhead to comb the hair. Agonizing pain that becomes worse at night and that may awaken the patient when he attempts to roll or turn on to the affected side is a usual complaint. As a result these patients persist in sleeping only on one side, to avoid recurrences even after the pain has disappeared. The diagnosis of simple acute traumatic bursitis may be made only when dislocations and fractures of the head of the humerus and tears of the short rotator tendons have been excluded, since injuries to these structures may be manifested by an acute bursitis, if by no other means. In most cases a careful history will establish the violence and character of the injury.

Bursitis with adhesions may be superimposed on the acute picture, after several weeks. Accurate diagnosis may then become extremely difficult, though the well advanced clinical picture of post-traumatic bursitis with adhesions is typical. The pain of injury subsides and is replaced by ill-defined pain over the shoulder, radiation to the insertion of the deltoid, to the elbow, or to the wrist and fingers, becoming progressively more severe. Usually there is atrophy of the spinatus, deltoid and arm muscles, often associated with vasospastic phenomena such as coldness and stiffness of the hand and a glossy atrophic skin. The bursa area is quite tender. the characteristic physical sign of bursitis with adhesions is the striking pain and limitation of active elevation of the arm. If the scapula is prevented from rotating, only 10 to 30 degrees of abduction of the affected arm may be present. Internal and external rotation also become greatly restricted.

Calcareous deposits frequently form in the supraspinatus tendon close to the greater tuberosity. Less frequently, they may be found in the subscapularis and the infra-spinatus tendon. Following insignificant trauma or without obvious cause, the patient begins to have pain in the shoulder localized over the bulge of the deltoid. Any of the symptoms previously mentioned may be present, plus acute agonizing tenderness over the greater tuberosity, on palpation, when the calcification is in the supraspinatus tendon or a little in front of or behind the tuberosity when the other tendons are involved. A milder form of calcareous bursitis may occur in the form of vague discomfort in the shoulder, aggravated by full elevation of the arm. If constant use of the arm is continued, ultimately the symptoms will disappear. Failure to use the arm, however, will result in adhesions between the bursal surfaces and may superimpose on the picture of mild calcareous tendonitis, the additional disturbance previously mentioned incidental to bursitis with adhesions.

Frequently roentgenograms are made of both shoulders for comparison, and calcareous deposits are seen in both, although only one shoulder is painful. Thus, the simple presence of a calcareous deposit does not in itself cause symptoms; the symptoms are due either to the inflammatory reaction about the deposit or to some mechanical interference with shoulder motion at the subacromial bursa. After many years of use,

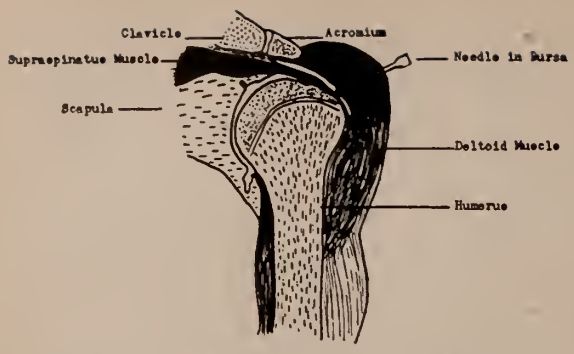


Figure 2. Needling of Subdeltoid Bursa.

the shoulder may exhibit evidence of wear in the form of fibrillations and minute tears of the supraspinatus tendon and roughening of the floor of the subacromial bursa. Thus any limitation of motion of the shoulder in elderly individuals may cause an adhesive subdeltoid bursitis. The possibility of other diseases such as cardiac, gallbladder, cervical syndromes, arthritis, tumors and other conditions must be carefully excluded, especially in the mild cases and those with some limitation of motion. X-rays are of value in ruling out the presence of other bony pathology, though of limited value in the direct diagnosis of subdeltoid bursitis.

Treatment.—In acute traumatic subdeltoid bursitis, the immediate relief of pain is the primary objective. If fluctuation is present, the bursa is aspirated and 5 to 10 ccs. of 1% procaine injected, with subsequent relief of pain and spasm. X-ray therapy, 50-100 roentgens, daily for 3-4 days is of value in some cases. Ice bags are advised during the first 24-48 hours and sedatives given as needed. The shoulder may be immobilized in partial abduction with a thick axillary pad and sling, relieving the tension of the shoulder muscles. After 3-5 days when acute symptoms have subsided, gentle exercise may be started. Bending forward at the waist, while swinging and then maintaining the arms forward and then straightening up will elevate the arms overhead without the abductor muscles having to exert themselves against pull of gravity. Doing this and similar types of exercises for three to five minutes four times daily should avoid adhesion formation and stiffening of the shoulder. Heat and gentle massage may be of some value now. Recovery may be complete in two weeks.

In post-traumatic adhesive subacromial bursitis, treatment is directed at separating the adhesions and restoring normal motion. Until this is accomplished, no permanent relief of pain can be expected. With mild symptoms and only moderate restriction of motion, the previously mentioned exercise plus a circular pendulum-like swing to the arm while bending forward at the waist, may be all that is necessary. X-ray is worthless here. Diathermy and heat are usually of help, and the patient is advised to use the arm as much as possible and sleep with it overhead. Salicylates and barbiturates are given in large doses early. With severe pain and marked restriction of motion, the adhesions must be separated by manipulation under local or general anesthesia. The humerus is slowly and gently fully elevated and internal and external rotation instituted. Great care must be exercised, as fractures of the humerus and/or calvicle may occur during manipulation. Opiates and salicylates are given, and the patient is instructed to elevate the arms overhead by means of various exercises within 24 hours of manipulation, even though great pain is caused. Faithful performance of these exercises, usually results in marked improvement within a few days.

In calcareous tendonitis of the short rotator muscles, treatment must again be directed at the immediate relief of the agonizing pain. Two methods are avalaible. First, by introducing a large bore needle into the calcareous deposit itself under procaine anesthesia, tissue tension may subside due to the escape of calcified material from the area and symptoms be alleviated. (Figure 2.) In most cases the calcareous deposit need not be completely removed, as any dispersion into the surrounding tissues will cause it to be rapidly absorbed. If the needle cannot be entered into the calcareous area and if the symptoms are exceedingly severe, under local anesthesia incision through the deltoid muscle and subacromial bursa with the extrusion of a mass of pasty, yellowish-white, tooth-paste like material, may give dramatic relief. Active motion should be started post-operatively, as soon as it can be tolerated by the patient.

SUMMARY

Subdeltoid bursitis is an inflammatory process, usually caused by trauma, affecting the bursa

lying between the under surface of the deltoid muscle and the outer surface of the joint capsule. Inflammation may be with or without calcification and/or with or without adhesions, but the supraspinatus tendon is usually involved in the pathology. Diagnosis in the acute stage is usually easily made on the history of acute severe trauma or mild repeated trauma, the severe to agonizing pain exemplified at night with tenderness over the bursal area of the deltoid muscle, and the position of the arm which is held fixed and rigid at the side, abduction attempts causing terrific pain and muscle spasm. Treatment consists essentially of temporary immobilization of the affected shoulder, injection or needling with procaine, surgery with incision and evacuation of the bursal contents, sedation, ice packs early and heat later in the course of the disease, and graduated exercises to avoid or to disperse adhesions.

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A Short Study of Iritis:
Significance of Early Diagnosis and Treatment

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The purpose of this paper is, of course, to bring a short review on iritis and the recent trends in its various phase; to emphasize the important points in early diagnosis and to mention the newer concept of treatment; iritis having been studied and treated for quite a long time. When one considers the diagnosis of this disease, it is well to emphasize the characteristic changes which generally occur. For instance, we must not forget that an iritis may also involve the ciliary body in an inflammatory process and bring about the well known condition called iridocyclitis; that such inflammatory conditions involve both anatomical structures, but it is impossible to see the vessels of the ciliary body and often difficult to notice those of the iris. What we do observe is an inflammatory picture of the deep ciliary vessels as they emerge over the sclera. Such picture differs in no way from the inflammatory stage of acute glaucoma, and iritis is frequently mistaken for conjunctivitis. Both mistakes are serious, and the glaucomatous error may be disastrous.

Fortunately we have a number of important signs in the differential diagnosis. In conjunctivitis there is generally more or less mucous discharge which glues the lids together. In iritis the secretions are thin and the lids are never glued together. There is edema of the iris; there is exudation; the aqueous humor becomes cloudy and filled with lucocytes. There is marked pain in the eye in an acute case but less marked or absent in chronic cases, and the main characteristic between this pain and that of inflammatory glaucoma is that in iritis it seldom brings on nausea and vomiting. In conjunctivitis there is hardly severe pain, the patient generally complains of a vague sensation of a foreign body in the eye. In iritis the pain is generally due to spasmodic contraction of the ciliary body and is naturally relieved by atropine. In iritis the pupil is generally small; in glaucoma, large. In glaucoma, moreover, the tension is increased; there are anesthesia of the cornea and rainbow vision around lights, and the use of atropine in glaucoma might be harmful — it may produce an increase in the intraocular tension. Hence the differential diagnosis between iritis and glaucoma becomes an important consideration.

Again, etiologically speaking, scientific experimental work reveals to us that iritis can be produced by actual placement of certain microorganisms in the eye, according to some observers; but in many instances however, it is difficult to demonstrate any evidence of bacteremia. Such cases were formerly ascribed to rheumatism but at present we have evidence that a great number of such conditions are due to foci of infection in various parts of the body. The usual common foci are generally found in the nasal accessory sinuses, teeth, tonsils, gall bladder, uterus and genitourinary tract. Thus, some observers and clinicians are impressed by the fact that iritis is produced by direct placement of bacteria in the eye — a hypothesis of bacteremia of rare occurrence, indeed; by systemic toxic conditions produced by microorganisms or released by autolysis of dead bacteria (toxemia); and finally by an allergy.

On the other hand, some observers deny the theory of direct inoculation. As to allergic manifiestation we have a good deal of evidence to show that this phenomenon is a real factor in the causation of ocular disturbances. We also find in our medical literature that an allergic response may be brought about from bacteria, their toxic products, or from different proteins even in such insignificant doses that they cause no systemic reactions. I observed in a number of iritis cases in private practice as well as in the clinics years ago that these were chiefly of tonsillar, dental, syphylitic, sinus and gonorrheal origin.

The course and consequences of an iritis are very important to remember, especially if com-

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plicated by iridocyclitis or iridochoroiditis. In most cases acute conditions associated with marked inflammation run a severe course, the average case of iritis lasting from one to two months — the first signs of improvement being decrease of the congestion and pain and prompt action of atropine. Chronic cases show but slight symptoms of inflammation; an iridocyclitis or iridochoroiditis may last a number of years. Relapse of inflammation in the iris and ciliary body are common, being due to renewal of the exciting cause rather than to mechanical effect of the adhesions which may have formed.

On the other hand, complete resolution may take place in mild cases if seen sufficiently early and the pupil kept dilated by atropine. Even if posterior adhesions or synechia of the iris has taken place, the pupil may fully dilate leaving, however, pigment spots upon the anterior capsule of the lens which do not become absorbed and may later be seen during the entire lifetime of the patient by oblique examination or the ophthalmoscope; they are generally complained of by the patient as floating specks before the eyes. Pus and exudates into the anterior chamber may disappear completely without surgical intervention but surgery may have to be resorted to in the more serious cases.

So among the chief of the clinical varieties to remember in connection with primary iritis and cyclitis is, of course, syphylitic iritis. Although the investigators and ophthalmologists of long ago spoke a good deal of this affliction — and although we have progressed in the fields of prophylaxis, diagnosis and treatment of syphilis, iritis and cyclitis are still produced by this disease. In fact, some observers claim that syphilis is responsible for at least one half of the cases of iritis. Iritis likewise occurs in hereditary syphilis, although not so frequently, being usually associated with interstitial keratitis, occurring early in childhood, while acquired syphilis usually is observed in adults.

Inflammation of the choroid is associated with more than half of the cases of syphilitic iritis and cyclitis; the retina and optic nerve are often involved. There is usually a tendency to recurrence. The actual diagnosis can be established only by demonstration of the presence of syphilis or the favorable action of antisyphilitic treatment.

Another clinical variety of this important disease is gonorrheal iritis. This disease is much more common than is generally believed, and many cases called rheumatic or allergic are really gonorrheal; and according to observers it occurs after gonorrhea, usually subsequent to an attack of arthritis and depends upon the influence of the gonococci or their toxins in the circulation upon the iris. It resembles the rheumatic form, the exudate is plastic (May).

The scrofulous variety bears a resemblance to the iritis of hereditary syphilis; occurs in anemic and scrofulous children and youths and often presenting a mass of exudate which appears to come from the angle of the anterior chamber.

In studying the various clinical types of iritis none are so confusing as the so-called idiopathic variety. This form of iritis still remains obscure as to etiology and many practitioners often attribute this trouble to a cold. The acute form is generally unilateral; the chronic form generally appears with symptoms of cyclitis and choroiditis, with light inflammatory symptoms and runs a long course. When it attacks persons of advanced age it is believed to be due to defective nutrition and it slowly progresses until blindness occurs.

We also have an iritis from septic infection from the teeth — pyorrhea and alveolar abscess; from the tonsils, nose or nasal accessory sinuses. In the past writers and clinicians spoke much about rheumatic, gouty and diabetic influences in connection with iritis and we still have to take these conditions into consideration.

Aother important variety is the traumatic. The causes of traumatism of all kinds, especially perforation of the eyeball, traumatic iritis and iridocyclitis are undoubtedly well known to all of us.

Lastly, I shall mention tuberculous iritis. This is rather a rare form which occurs cheifly in children and young adults — with or without tuberculosis condition in other parts of the anatomy. However, we recognize more or less two forms of this type of iritis: (1) the miliary, in which we find small grayish-yellow nodules develop near the ciliary or pupillary margin, and (2) the conglomerate form in which a single yellowish-gray mass or deposit is found in the pupillary part of the iris. In mild cases the tuberculosis deposits may be absorbed; in the more severe type the process may lead to dan-

gerous consequences and even to utter destruction of the eyeball.

As to prognosis and consequences of an iritis, there is no mystery in the fact that an iridocyclitis is more serious than that of a simple iritis; and the consequences of an iritis or iridocyclitis which threaten the function of the eye are exudates and adhesions or synechiae. Obviously when posterior synechiae are small they produce little or no damage to vision, but when circular, the drainage of the nutrient liquid supplied by the ciliary processes from the posterior to the anterior chamber is interfered with and the accumulation of the liquid in the posterior chamber causes a bulging and finally brings atrophic changes in the iris. When the pupillary area is filled with exudate the sight is naturally impaired. When an exudate enters the lens tissue and becomes imbedded there, a cataract results, undoubtedly from faulty nutrition; when the exudate displaces the vitreuos, shrinking of the bulb follows and the patient goes blind.

Methods and medicinal preparations employed in the treatment of iritis are varied and numerous. With the advent of penicillin and other antibiotics for gonorrhea and syphilis, with insulin in diabetes, with sulfa such as sulfathiazole, pansulfa, sulfanilamide, sodim sulfacetimide, etc., for the local and internal administration, we have a good deal more at present than we had a few short years ago.

However, the ideal treatment of iritis (except the systemic conditions mentioned above) is one that will most nearly fulfil the following requisites: relieve pain, prevent adhesions, constitutional treatment and if necessary, surgical intervention.

Aureomycin and terramycin are two antibiotics not to be overlooked in ophthalmic disease, especially in iritis. Drugs such as ACTH and cortisone were reported used in acute iritis by a group of ophthalmologists with varying results. Thus, T .D. Spies and R. E. Stone report the good effect of the local application of synthetic cortisone acetate on the lesions of iritis and uveitis (Southern Med. Jour. Oct. 1950). In his preliminary report on the action of pituitary adrenocorticotropic hormone on certain inflammatory eye diseases including acute plastic iritis (Jour. A.M.A. April 22, 1950), J. A. Olson presents a very favorable picture of his four patients with acute iritis; he also mentions two patients with anterior uveal tract involvement. All patients responded abruptly and favorably to hormonal therapy. Penicillin if required, is given in the form of injections every 2 or 3 hours — 600,000 units daily for a number of days until favorable reaction takes place.

Among the surgical procedures advocated in connection with complicated conditions of iritis are: paracentesis, iridectomy and enucleation. When the symptoms of sympathetic inflammation and iritis are slight, enucleation of an injured eye may save the other; but when the condition is very severe and the symptoms are well developed, no treatment is of any value.

Paracentesis and iridectomy are advocated for the relief of persistent increase of tension ocurring during the acute stage of iritis and iridocyclitis. Paracentesis should first be tried and if unsuccessful, an iridectomy should be considered in the event the iris has not undergone important structural changes.

We find that small localized posterior synechiae often yield to atropine and holocaine treatment; also pilocarpine or eserine, followed by atropine whereby the pupil is dilated after myosis has been accomplished, is a very good method in the small synechiae; but more extensive synechiae resist all but surgical procedure. 3109½ N. Lincoln Ave.

COUNCIL MEETING MINUTES



The regular October meeting of the Council was held at the Hotel Sherman, Chicago, Sunday, October 28, 1951; the following were present: Blair, White, Sweeney, Muller, Lundholm, O'Neill, Greening, Stone, Oldfield, Vaughn, Reichert, Pearis, Newcomb, Hamilton, Hulick, English, Montgomery, Fullerton, Hedge, Hopkins, Hutton, Coleman, Cross, Hellmuth, Limarzi, Neal, Leary, Camp and Frances Zimmer. Secretary reported sudden death of Walter Stevenson, told of request of family that instead of sending flowers, those desiring to do so, send remittance to the Society's Benevolence Fund.

Minutes of last meeting were approved (Fullerton-Montgomery). Secretary read financial report — which was approved (Hamilton-Stone). White reported as president, telling of his official activities since last meeting. Complimented C.M.S. for fine programs and attendance at recent P.G. conferences. Visited State Societies of Wisconsin and Kentucky, the latter having their centennial meeting recently at Louisville. Recommended to Journal Editorial Board that they use public relations short filler in the Journal, such as "Around the Clock Medical Service is good public relations"; "Good American Citizens today will vote", etc.

Sweeney as President-Elect told of recent meetings he had attended, commenting on same. Told of the successful Annual Dinner of the C.M.S. and referred to the work of the Committee on Medical History of this Society, having attended a recent meeting. Recommended changes in appearance of Fifty Year Club and Emeritus Certificates, which will be given further consideration.

Stated that the members of the Council from the C.M.S. recommend Fred H. Muller as General Chairman, Committee on Arrangements for the 1952 annual meeting.

Motion (Hedge-Montgomery) that Council approve Muller as General Chairman. Carried.

Cross, as Director, State Department of Public Health, told of the cooperation of his Department with State Director of Civil Defense, making personnel of the Department available for work in the program as set up. The 100 bed State Tuberculosis Hospital at Mt. Vernon has opened, and has some 70 bed patients, and 25 out patients at this time. Hospital manned with superintendent and two staff physicians at present. The Chicago Tuberculosis Hospital should be open about July, 1952. Two narcotic stations have been set up and should be in operation by the end of this year: research will be emphasized as no treatment, as such, can be given in the program. Dr. Shuman, epidemiologist with the State Department has been loaned to the U.S.P.H.S. for epidemiological services in Korea for a period of 8 months. Cross has completed 12 years as Director of the Department of Public Health.

Reports of individual councilors were given: Lundholm attended a meeting honoring J. B. Schreiter, Savanna, recently designated as the outstanding general practitioner of Illinois for 1952. The city of Savanna and surrounding area, very enthusiastic, and use every opportunity to honor their outstanding physician. O'Neill referred to recent public relations meeting held at LaSalle, which was a good meeting in spite of inclement weather. Referred to new hospital recently dedicated in Mendota, this constructed entirely from local funds, no state or federal assistance received. The entire community behind the project and they deserve much credit for the accomplishments.

Vaughn referred to the night call service maintained by the C.M.S. which started last June and has been unusually successful. Also referred to recent C.M.S. P.G. Conferences. Stone likewise referred to the C.M.S. P.G. Conferences, 82 registered for the one on Endocrinology, and 196 for the one on Obstetrics and

Gynecology. Dinner conference held during the conferences with 248 at the dinner, and 300 or more at the evening meeting. Dinner costs included in the student fee for the conferences.

Reichert stated that the Illinois Chapter of the American Academy of Pediatrics was pleased with the printed copies of the pediatric survey, and thanks the Council for having it properly abstracted and printed. These were presented at the recent meeting of the Academy held in Toronto, and all were pleased with the relationship of the two societies in Illinois, and also the fact that the Illinois Chapter holds its annual session in conjunction with the annual meeting of this Society. Complimented Dr. Shuman of the State Department of Public Health for the fine report he gave, and on the basis of the report there was no evidence to stop immunization programs during the polio season, except in severe epidemics.

Muller reported as Vice President, referring to recent meetings and conferences he has attended. Wanted Council instructions relative to the Illinois Delegates at the Clinical Session of the A.M.A. to be held December 4-7 in Los Angeles, Muller being Chairman of the Illinois Delegation. Commented briefly on the C.M.S. night call service; all patients returned to their regular family physician, with a report given him by the one making the night or emergency call.

Oldfield referred in some detail to the plan used in Oak Park relative to the annual chest x-ray survey. The family physician played the leading role in the entire survey. A post card is mailed by the physician to his patient telling him to report for the chest x-ray; the Unit returns the film and form to the physician, who in turn tells the patient of the result.

Newcomb stated that he has met with most of the societies in his district. Told of recent meeting held in White Hall and arranged by the Committee on Nutrition, which was well attended and with an excellent program. Also referred to the public relations conference held at Edwardsville, with Neal, Leary and Camp on the program, an excellent attendance and meeting went over well.

Hulick referred to the postgraduate conferences held at Decatur, as arranged by Dr. Hellmuth. Nearly 200 for the dinner meeting and over that number of physicians registered for the session. Compliments Hellmuth and hopes the Council approves the setting up of additional conferences around the state in accordance with Hellmuth's desires.

Montgomery attended a number of meetings in his district, one of the six county societies held recently at Benton. This a good way to get good meetings and scientific presentations in the more sparsely settled communities.

Fullerton has visited five of his county societies, and has been in contact with the other four. Has received some criticisms of the U.M.W. program, to be referred to the Society Advisory Committee to the U.M.W. Health and Welfare Fund. Comments on postgraduate conferences for the southern end of the state, to be referred to Dr. Hellmuth. Believes we should stress the advisability of taking policies with greater protection to the subscriber of mal-practice insurance. These now available at a slightly increased cost.

Hopkins reported as Chairman of the Committee on Medical Service and Public Relations; plans under way to set up information courses for students in medical schools on the subject of organized medicine, its aims and functions.

Neal discussed several matters, including the licensure of physicians under the new limited license given to men who are to become employed by the State Department of Public Welfare. Also commented on work of Senator Dirksen in committee, on proposal to give federal aid to medical schools — Dirksen as would be expected, was opposed to federal government becoming financially interested in medical education.

Leary referred to public relations meetings already presented at Decatur, Kankakee, LaSalle, Quincy and Edwardsville. Others desired and plans not yet made for them. Told of recent public relations survey made in Decatur by Mr. Rember of the AMA. This will be reported soon and will be an interesting report. Told of his release concerning Dr. Schreiter and also preparing material to be submitted to the A.M.A. Board of Trustees relative to Dr. Schreiter, the Society's candidate for outstanding general practitioner of the nation.

Hopkins discussed the prepayment care plans, and their progress. Referred to status of Grievance Committee, with recent death of its chairman, Stevenson. Committee to meet soon and elect new chairman and in meantime Hopkins has the files in his possession.

Coleman discussed work of Advisory Committee to the I.P.A.C. — meeting held the previous evening was reported. Plan to have direct payment to physicians in operation February 1. Readjustment on payment of hospital bills now in operation, will be tried out for a six month test period. Now paying for services rendered rather than the old flat rate method which had been in operation. Coleman also told of recent meeting of Advisory Committee to the U.M.W., and mentioned some recent problems. Believes this committee has been of real service to the U.M.W. group, and eventually will work to the best interests of the profession.

Hutton reported recent progress of the medical history committee, telling of the work now in progress; hope to have sufficient material available for an editor after the first of the coming year. Dr. D. J. Davis devoting major part of his time on the work, and doing a fine job.

Council went into executive session for some considerations which had been presented. Several actions taken on current bills which had been presented for payment.

Limarzi gave his report as chairman of the Scientific Service Committee, telling of services rendered to various societies since last meeting of the Council. Also discussed work of his Blood Bank Committee, referring to questionnaires sent to all Illinois Hospitals asking for information. Will have report prepared from these questionnaires at the January meeting.

Newcomb presented the report for the Committee on Nutrition, as prepared by the chairman, Dr. L. T. Hoyt. Referred to meeting held recently in White Hall — also his attending the meeting on the follow-up committee of the White House Conference to consider especially two matters (1) Dietary recommendations for the present war emergency, and (2) methods of improving the nutrition of children throughout the state through a more efficient cooperation of Home Advisors, Departments of Welfare and Public Health, and School Lunch Programs.

Blair gave the report for the Educational Committee; television and radio programs subjects, and procedures. Referred to A.M.A. conference in New York on TV health programs, attended by Miss Fox; the general theme at this conference, "Building the Health Education Telecast". Radio Station WFJL continues to carry the "Your Doctor Speaks" programs.

Hellmuth gives the report for the Postgraduate Committee, commenting on the program given at Decatur. Would like permission to schedule four more conferences, and asks for a budget to cover all necessary expenses for preparing and presenting them. Has four recommendations :(1) The Committee be authorized to cooperate with the Illinois Chapter American Academy of General Practice to develop an educational program mutually beneficial.

(2) The Committee be authorized to select in special cases, men of high caliber who are not "M.D.s" to appear on the programs.

(3) Approval of their budget recommendation and authorization for five conferences to be scheduled by the committee for the current fiscal year.

(4) Committee desires authorization to include in the official printed programs, short abstracts of the material to be presented.

Motion (English-Sweeney) that these recommendations be approved. Carried.

Several letters were submitted for necessary Council action, all of which were properly considered and acted upon.

A list of 13 physicians was submitted as candidates for Emeritus Membership, all having been so recommended by their component society. Six candidates for Past Service Membership and one for Retired Membership also submitted.

Motion (Vaughn-Fullerton) that same be approved and elected accordingly. Motion carried.

Bills as audited by Finance Committee were approved. (Hamilton-Stone).

The Council adjourned at 3:30 P. M., to meet again in regular session on January 6, 1952.

Harold M. Camp, M.D.
Secretary

SURGERY FOR BONE TUBERCULOSIS

Most of us have been taught that tuberculosis of the bones and joints should be treated by so-called conservative nonsurgical methods. Many of the old teachings still cling to us. Calot said, "If you open tuberculosis you thereby open the door for death." Rollier's slogan was, "Every tuberculosis can be healed if we have only the patience not to operate." Most of us have seen the disastrous results following a surgical procedure with secondary infection in a tuberculous bone or joint. However, since we now have powerful antibiotics and chemotherapeutic agents, we may change our concepts of the treatment of tuberculosis of bones and joints and get rid of some of the old taboos that had their origin in the days when antibiotic and chemotherapeutic aids were not available. . . The following are the prerequisites for surgical treatment of bone and joint tuberculosis:

1. Little or no fever.
2. No active pulmonary lesion.
3. Low sedimentation rate.
4. Rest, adequate nutrition, blood transfusion and general support.
5. Streptomycin and para amino salicylic acid.
6. Immobilization of the affected part.

Unless there is complete removal of the diseased tissue, there might be reactivation of the disease and formation of sinus tracts. Gentle handling of tissue and clean, sharp dissection will help prevent a hematogenous spread due to surgical manipulation, although this complication must be rare. Gentle debridement and meticulous avoidance of the epiphyseal plate will prevent growth disturbance. *Excerpt: Tuberculosis of Bones and Joints in Children, W. L. Minear, M.D., Hot Springs, N. Mex., The Amer. Surg., Sept. 1951.*

REMEDIES FOR THYROTOXICOSIS

The physician now has several resources when confronted with a patient with thyrotoxicosis. He may employ the chronic administration of a thiourea derivative, or he may give the patient radioactive iodide, or he may elect to prepare the patient with one of the thiourea derivatives and then have the gland surgically removed. There is perhaps a residual small group of patients who can be controlled perfectly well by the administration of Lugol's solution or saturated solution of potassium iodide. The choice of therapy depends on a variety of considerations. In any form of treatment there is risk not only to the patient but the risk of not securing an entirely satisfactory result. The degree of toxicity is a factor and so is the age of the patient. Previous sensitivity to drugs must be taken into consideration. This was illustrated recently by a patient who had developed agranulocytic angina following administration of methyl thiouracil. She not only had a single nodule of her thyroid, which required surgery on its own merits, but in addition she was thyrotoxic. The toxicity prevented surgery. The recourse was to radioactive iodide to take care of the toxicity. As soon as this was under control the incidental nodule was removed. We have recently been informed of a similar patient where a very large nodular goiter was obstructing the esophagus, and yet surgery was impossible because the toxicity from the old multinodular gland was such as to embarrass the heart to a degree that surgery seemed contra-indicated. The patient was given radioactive iodide which successfully controlled the toxicity and in due course he was a suitable candidate for resection of the thyroid. This case was successfully handled by Dr. Andreis Querido of Leiden, Holland. In such cases one might think of radioactive iodide as being used as preparation for surgery.

No hard and fast rules can be given for a choice of therapy in thyrotoxicosis. The many considerations must be weighed by the physician and balanced one against the other. It is fortunate that several forms of effective treatment widen the scope and enhance the nicety of therapy in that they enable the physician to individualize his choice for the situation at hand. *Excerpt: The Physiologic Basis for the Therapy of Hyperthyroidism, John B. Stanbury, M.D., Boston, Boletin de la Asociacion Medica de Puerto Rico, July, 1951.*

HEAD INJURIES

Methods of treating traumatic cerebral edema are controversial. We feel that frequent lumbar punctures with the idea of reducing pressure for any appreciable time are useless. A lumbar puncture is important in almost every case of suspected head injury simply to establish the presence of blood in the subarachnoid space and thus have available irrefutable evidence of cerebral contusion—important both prognostically as a base line and medicolegally. Occasionally, the removal of a small amount of very bloody spinal fluid may quiet a restless and agitated patient but frequent, repeated lumbar punctures with any feeling that one is treating diffuse cerebral edema seem useless. Dehydration is more dangerous than helpful in handling this problem. The old operation of subtemporal decompression is no longer considered of any value in treating acute head injuries. It is never adequate to control pressure and usually only makes the situation worse when the edematous cortex bulges into the bony opening and cortical veins are compressed. Adequate cerebral oxygenation, normal fluid and electrolyte balance are of much greater value than any of these older methods of treating acute, closed head injuries. *Excerpt: A Few Practical Points in the Treatment of Acute Head Injuries, George L. Maltby, M.D., J. Me. M.A., Aug.* 1951.

NEWS OF THE STATE



CHAMPAIGN

News from Champaign County.—"Surgical Correction of Congenital Cardiac Lesions" was discussed by Dr. William L. Riker, pediatric surgeon, Children's Memorial Hospital, Chicago, before the Champaign County Medical Society, November 8. The society was also addressed recently by Dr. Marc Hollender, assistant professor of psychiatry, University of Illinois College of Medicine, on "Psychological Approach to Everyday Problems in Medicine." A member of the society, Dr. Hans M. Buley, has been requested to present a paper entitled "German School of Dermatology in the Past Century" before the American Academy of Dermatology and Syphilology in Chicago, Dec. 8-13. New members of the society are Drs. George Agate and Charles Roland.

Outstanding Practitioner.—Dr. L. O. Sale, Fisher, was chosen outstanding general practitioner of the year by the executive committee of the Champaign County Medical Society. Dr. Sale has been practicing in Fisher since 1896. Seventy-nine years of age, he is a past president of the society, a charter member and director of the Fisher Lions Club, former member of the Fisher Village Board and former treasurer of the Fisher Methodist Church.

COOK

Lectures on Cancer.—The Medical School of Northwestern University is offering a Cancer Lecture Series for the second consecutive year on Wednesday afternoons from five until six o'clock in Thorne Hall on the Chicago campus. The series, which began on October 10, included ten talks by prominent physicians in the field of cancer research. The first program was presented by Dr. Robert A. Moore from Washington University School of Medicine, October 10, who talked on "The Nature of Cancer."

The two succeeding programs were lectures by Dr. W. A. Anderson of Marquette University on "Tumors and Tumor-Like Conditions of the Thorax" and "Cancer of the Pancreas" by Dr. Lester R. Dragstedt, University of Chicago.

Other participants included:

October 31: "Physiological Concepts in Cancer" by Dr. Rulon W. Rawson, Chief of the Department of Medicine, Memorial Hospital, New York

November 7: "Cancer of the Breast" by Dr. C. D. Haagensen, Professor of Surgery, Columbia University College of Physicians and Surgeons

November 14: "Metastases" by Dr. Morton McCutcheon, Professor of Pathology, University of Pennsylvania Medical School

November 21: "Newer Concepts of Cancer Therapy" by Dr. Danely P. Slaughter, Assistant Professor of Surgery, University of Illinois College of Medicine

November 28: "Multiple Myeloma" by Dr. Steven O. Schwartz, Professor of Hematology, Chicago Medical School

December 5: "Radiotherapy in Cancer Control" by Dr. Ivan H. Smith, Director of Ontario Cancer Foundation Clinic, University of Western Ontario

December 12 "Estrogens and Cancer" by Dr. L. A. Emge, Professor of Obstetrics and Gynecology, Stanford University School of Medicine."

Branch Meeting.—A panel discussion on diabetes was the theme of the November 6 meeting of the North Shore Branch of the Chicago Medical Society. With Dr. Ralph E. Dolkart, assistant professor of medicine, Northwestern University Medical School, acting as moderator, members of the panel were Drs. Arthur R. Colwell, professor and chairman of the department of medicine at Northwestern, Randall G. Sprague, assistant professor of medicine, Mayo Foundation, and Henry T. Ricketts, a professor of medicine, University of Chicago School of Medicine.

Appointments to University Council Committee.—Seven University of Chicago faculty members of the supreme academic body of the university, the Council have been elected to the Council Committee. The Committee, which is the steering group on matters of educational policy within the jurisdiction of the university Council, meets every two weeks. Elected members of the Committee for 1951-52 are: Earl A. Evans, Jr., chairman of the department of biol-chemistry; Dr. Paul C. Hodges, professor of radiology; Robert Redfield, chairman of the department of anthropology; W. Allen Wallis, professor of statistics and chairman of the Committee on Statistics; Harold R. Willoughby, professor of Christian origins; Quincy Wright, professor of international relations; and William H. Zachariasen, professor of physics. Evans, Willoughby and Zachariasen are newly elected members of the Committee. The others are re-elected for another term.

Personal.—Dr. Joseph L. Baer has resigned as vice president of the American Board of Obstetrics and Gynecology, a position he held for more than twenty years. He has been succeeded by Dr. John L. Parks, Washington, D.C.—Dr. Max Thorek gave the first Annual Frank C. Henry Jr. Memorial Lecture before the Academy of Medicine of the Raritan Bay Area, October 17, in Perth Amboy, N.J. He spoke on "Impending Death Under Anesthesia", which was illustrated by a motion picture.—Dr. M. A. Perlstein, Dr. Harry Barnett and Dr. Jerome Finder, all of Chicago, cooperated in an exhibit on miniature cerebral palsy equipment before the American Academy of Pediatrics meeting in Toronto, Canada, October 22-25.—Dr. Philip Thorek discussed "Practical Aspects of Inguinal Hernia" before the Greenwood Medical Society in Greenwood, S.C., October 24. The following day he addressed the Georgia Academy of General Practice in Macon on "Acute Abdominal Emergencies."

Special Society Election.—Newly elected officers of the German Medical Society of Chicago are Dr. Heinrich G. Kobrak, president; Dr. William A. Marshall, vice president; Dr. Eugene F. Lutterbeck, secretary, and Dr. Fidelius Knoepfler, treasurer.

News from Chicago Medical School.—Four scholarship gifts totalling $34,000 have been received by the Chicago Medical School, according to an announcement issued by President John J. Sheinin. In memory of his father Dave Hokin who died in 1949, Myron Hokin, 4950 South Chicago Beach Drive, President of the Century America Corporation, announced a gift of $14,000 from the Dave Hokin Foundation of which he is President. $10,000 is for a subsidiary scholarship, which makes up the difference between what a student pays in tuition and what it costs the school to provide four years of medical training. $4,000 is for additional scholarship use to be assigned by the school. A subsidiary scholarship of $10,000 was given by Samuel Briskin, 2300 North Lincoln Park West, Chairman of the Board of the Revere Camera Company. A gift of $10,000 to be known as the Barney Ets Hokin subsidiary scholarship, was given by three officials of the International Rolling Mills Products Corporation: Barney E. Hokin, 4950 South Chicago Beach Drive, President; Edwin E. Hokin, 199 Lake Shore Drive, Vice President; and Edward M. Rabin, Lake Shore Drive Hotel, Vice President. The Chicago Medical School has received four grants for research totalling over $20,000. $6,000 from the National Cancer Institute, United States Public Health Service, goes to Dr. A. C. Ritchie, Research Fellow, studying factors influencing cancer production in animals, in the Department of Cancer Research of which Dr. Philippe Shubik is head. Dr. Israel Davidsohn, Professor and Chairman, Department of Pathology, and Director of Laboratories, Mount Sinai Hospital, received $6,588 from the United States Public Health Service for work on hemolytic anemia. Dr. Philippe Shubik, Assistant Professor and Co-ordinator of the Cancer Teaching Program, Department of Surgery, and Dr. A. Robert Goldfarb, Associate, Department of Biochemistry, received $2,500 from the Atomic Energy Commission for studies of cancer-producing effects of Beta radiations. Dr. Aldo A. Luisada, Associate Professor of Medicine and Program Director of Cardiology, Department of Medicine, is given $5,400 by White Laboratories, Inc., for continuation of studies of gitaligin, one of the new digitalis derivatives.

Tom Jones Honored.—An award has been established by the Biological Photographic Association in honor of Prof. Thomas S. Jones, professor of medical and dental illustration and head of the Illustration Studios at the University of Illinois.

The award, officially known as the Tom Jones Award, will be given annually for the best paper to be published in the Journal of the Biological Photographic Association.

The award consists of a certificate which was designed by Prof. Jones. It was named for him in recognition of his many contributions to the Association.

KNOX

Society News.—At the regular monthly meeting of the Knox County Medical Society at the Galesburg Club, Galesburg, October 18, Dr. Ray G. Bunge, associate professor of urology, University of

Iowa School of Medicine, Des Moines, discussed "Problems in the Diagnosis of Renal Tumors."

MACON

Society News.—At a meeting of the Macon County Medical Society in Decatur, October 23, Dr. Roland N. Klemme, professor of neurosurgery, St. Louis University School of Medicine, spoke on "Acute Intra-cranial Lesions."

Grievance Committee Organized.—The Macon County Medical Society has established a grievance committee, which was to be in operation November 1. According to the society's bulletin, the primary objective of this committee is to see that the public interest is fairly and honestly served and to correct misunderstandings and abuses which patients believe have occurred. A non-medical member has been purposely included on the committee to represent the layman's point of view.

McDONOUGH

Society Election.—At a meeting of the McDonough County Medical Society, October 26, the following officers were elected: O. A. Dively, Macomb, president; R. L. Franck, Bushnell, first vice president; R. F. Millet, Macomb, second vice president. Dr. R. C. Benkendorf, Macomb, was re-elected seceretary-treasurer. V. B. Adams, Macomb, was chosen delegate to the Illinois State Medical Society, and R. G. Trummel, Bushnell, alternate. Albert Havens, New Philadelphia, was inducted into the Fifty Year Club of the Illinois State Medical Society with the presentation of the insignia by Dr. C. Paul White, Kewanee, President-Elect of the state society. The county society was addressed at this meeting by Elizabeth A. McGrew, assistant professor of pathology, University of Illinois College of Medicine on "Genital Tract Carcinoma in Asymptomatic Women."

MORGAN

Society News.—The Morgan County Medical Society was addressed recently by Dr. Joseph A. Capps, emeritus professor of clinical medicine, University of Chicago School of Medicine, on "Pain, Its Nature and Distribution"; Dr. Hugh M. Wilson, head of the Mallinckrodt Institute of Radiology, Washington University School of Medicine, St. Louis, on "The Development of Radiology", and Dr. James H. Hutton, Chicago, "Medical Practice in Illinois a Century Ago." Both Dr. Capps and Dr. Wilson are natives of Jacksonville, the site of the first medical school in the state which closed in 1848.

ROCK ISLAND

Interprofessional Meeting.—The second annual Interprofessional meeting of the combined membership of the Rock Island County Medical Society, the Rock Island County Dental Society and the Rock Island County Pharmacists Association was held at the Plantation in Moline, Nov. 13.

WINNEBAGO

Society News.—"Non-Microscopic Hematology" was the subject of Dr. Steven Schwartz, director of hematology Laboratory, Cook County Hospital, Chicago, before the Winnebago County Medical Society in Rockford, November 13.

GENERAL

Meeting on Mental Health.—The first annual dinner meeting of the National Association for Mental Health was held at the Stevens Hotel, November 30. The meeting marks attainment of a long-standing aim — a national voluntary organization integrating the work of mental hygiene societies in all parts of the country.

Speakers were Oren Root, president of the new association; Governor Adlai E. Stevenson, and Dr. William C. Menninger, noted psychiatrist, who discussed Men, Machines and Mental Health. The program included the midwest premiere of an American Theatre Wing play, presented by Chicago Junior League players.

Host was the Illinois Society for Mental Hygiene, 123 West Madison Street.

The National Association for Mental Health was formed by merger of the National Committee for Mental Hygiene, the National Mental Health Foundation, and the Psychiatric Foundation. The second step was to bring the many state and local mental health societies into organizational relationship with each other and the new national association. Objectives of the association and its affiliates are:

1. Development of psychiatric services for all who need them at prices which they can afford to pay.
2. Spreading knowledge about mental health so that every person may be better able to cope with his own needs and better able to discharge his obligations as a citizen.
3. Recruitment and training of more and better personnel in the professions having to do with mental health and mental illness.
4. Widening the area of knowledge by increased research into the causes and treatment of mental illness.

DEATHS

Dr. Louis Herman Block, Chicago, who graduated at Loyola University School of Medicine in 1919, died Aug. 6, aged 59, of coronary insufficiency.

Dr. George C. Busch, Chicago, who graduated at Rush Medical College in 1899, died Aug. 13, aged 73, of cerebral hemorrhage, and carcinoma of the colon.

Bert Wilmer Caldwell, Rockton, who graduated at Barnes Medical College in 1898, died July 26, aged 76. He was a veteran of the Spanish-American War and World War I; for many years executive secretary of the American Hospital Association and from 1936 to 1942 editor of its magazine HOSPITALS.

Walter W. Coen, Chicago, who graduated at Chicago College of Medicine and Surgery in 1916, died November 5, aged 59, in Springfield while returning from a vacation.

Thomas Levi Dagg, Chicago, who graduated at

University of Michigan Department of Medicine and Surgery in 1899; formerly on the staff of St. Luke's Hospital; died Aug. 9, aged 83, of arteriosclerotic heart disease.

Lourdes B. Gordon, Oak Park, who graduated at St. Louis University School of Medicine in 1931, died Oct. 17, aged 46. He served in World War II in the navy as a commander.

George Dillard Harber, Chicago, who graduated at Emory University (Ga.) School of Medicine in 1933, died Aug. 4, aged 54, of coronary thrombosis and hypertension.

Anthony S. Ippolito, Chicago, who graduated at Stritch School of Medicine of Loyola University in 1943, died Nov. 13 in a train wreck near Evanston, Wyo. He was 34.

Alex E. Ludwig, Chicago, who graduated at Chicago Homeopathic Medical College in 1901, died Aug. 17, aged 73, of pneumonia and arteriosclerosis.

Donald John McGrew, Lake Forest, who graduated at Loyola University School of Medicine in 1932, died Aug. 8, aged 51, of carcinoma. He was past president of the Lake County Medical Society.

Fusa T. Nakaya, Chicago, who graduated at the University of Illinois College of Medicine in 1917, died Oct. 21, aged 64. He practiced medicine for many years in Los Angeles before returning to Chicago.

Nathan G. Short, retired, Chicago, who graduated at the Hahnemann Medical College and Hospital in 1906, died recently, aged 81. He was a staff member of the Chicago Board of Health for more than 40 years.

Paul R. Sowden, Evanston, who graduated at The Chicago Medical School in 1932, died as the result of an automobile accident Oct. 22, aged 51. His offices were located in Markham.

John L. White, Chicago, who graduated at Northwestern University Medical School in 1924, died Nov. 14, aged 62, in Rochester, Minn. He had been a member of the Chicago Board of Health since 1910, and chief sanitary officer since 1948.

Rutherford Marcus Williams, Chicago, who graduated at Howard University College of Medicine, Washington, D. C., in 1918, died Aug 22, aged 74, of coronary heart disease.

Ralph H. Woods, retired, LaSalle, who graduated at the University of Illinois College of Medicine in 1913, died Oct. 16, aged 75. He had practiced in the field of ophthalmology until his retirement in 1948. He was the author of a number of musical compositions as well as medical articles.

INJURY TO THE HEART

Although severe wounds to the heart and adjacent great vessels usually result in death, there are possibilities for applying procedures which may be life-saving. In some cases conservative treatment may be effective. Severe contusion to the heart, when not complicated by pericardial effusion, may be treated by methods used for coronary occlusion. Pericardial aspiration may be used in treating penetrating wounds which cause tamponade—silent heart, increased diameter of the cardiac roentgenologic shadow, increased venous pressure, and decreased arterial pressure. But if there is no clinical improvement despite such measures and the cardiac wound continues to bleed, thoracotomy is indicated. The approach is through the left fourth interspace, with division of the fourth and fifth costal cartilages. When the pericardium is opened, suction is applied to remove the blood while search is made for the wound. Moderate pressure with the index finger will usually control the bleeding while the wound is closed with interrupted silk. A heavy silk suture passed through the apex of the heart may aid in steadying or displacing the heart so that suturing can be done more easily, but it must be remembered that such displacement can cause pronounced circulatory depression. *Excerpt: The Surgical Treatment of Acquired Heart Disease, Frank Gerbode, M.D., San Francisco, Calif. M., Sept. 1951.*

"FOR THE COMMON GOOD"

Health Talk on TV.—Since the last issue of the ILLINOIS MEDICAL JOURNAL, the following telecasts have been presented by the Educational Committee over WGN-TV, Channel 9, on Tuesday evenings at 7 p.m.:

Steven O. Schwartz, October 30, Bleeding and Bruising, with William W. Bolton acting as moderator.

M. David Allweiss, November 6, The Story of Diabetes. Equipment for this telecast was provided by the Denoyer-Geppert Company.

Louise Tavs, November 13, Cosmetics and You.

Eugene A. Hamilton, November 20, Splint 'Em Where They Lie.

Barium Demonstration Success on TV.—The telecast, "Physiology of Digestion", presented over WGN-TV, October 9, showed clearly the effectiveness of fluoroscopic demonstrations by television. This was the first time that a fluoroscopic image of the action of barium in the alimentary canal was given to the public. Studio engineers and Mr. Byron S. Hess of Standard X-Ray Company again cooperated in putting on another "first." The Standard X-Ray equipment has proved most satisfactory in projecting fluoroscopic demonstrations. The company is to be thanked for leaving their equipment in the studios of WGN-TV for two consecutive weeks to televise two different types of programs.

The successful production of Health Talk over WGN-TV can be attributed to a large extent to all firms and hospitals who have cooperated so extensively in assisting the Educational Committee of the Illinois State Medical Society by providing equipment. These firms include Bausch and Lomb Optical Company; Clay-Adams Company, Inc. Surgical Supplies; Camera Exchange; Precision Scientific; Ohio Chemical and Manufacturing; Cambridge Instrument; Sanborn Company; Picker X-Ray; Audio Development Company; Central Scientific; Nuclear Instrument and Chemical; Zimmer Splint; Standard X-Ray; William Ballert and Company; V. Mueller and Company Surgical Supplies; Continental Scale; Sportsman Club of America; General Electric X-Ray; Denoyer-Geppert Company and Abbott Laboratories.

Your Doctor Speaks Over WFJL, Thursday evenings at 7:30 p.m., carried the following transcribed broadcasts under the auspices of the Educational Committee since the last issue of the JOURNAL:

Michael H. Streicher, November 1, Colitis.
Matthew Block, November 8, Your Blood.
Stanley Fahlstrom, November 15, Arthritis.
Arno Leshin, November 22, Plastic Surgery.

Lectures Arranged Through the Educational Committee:

Ben Z. Rappaport, Chicago, November 5, Jewish People's Institute, Allergies.

Fred Robbins, Chicago, November 12, Young Women's Christian Association, Mental Health.

Louis R. Limarzi, Chicago, November 12, Jewish People's Institute, The Story of Blood.

Eugene F. Lutterbeck, Chicago, November 19, Jewish People's Institute, Basic Principles of Radiation Therapy.

Irwin R. Callen, Chicago, November 26, Jewish People's Institute, Heart Disease in the Aged.

Samuel M. Bluefarb, Chicago, December 3, Jewish People's Institute, Care of the Skin.

G. J. Kidera, Berwyn, December 4, Morton High School, Medicine As a Career.

Irving E. Steck, Chicago, December 10, Jewish People's Institute, What You Should Know About Arthritis.

Eugene A. Hamilton, Chicago, December 17, Jewish People's Institute, Fractures of the Hip and the Painful Back.

Lectures Arranged Through the Scientific Service Committee:

Theodore J. Wachowski, Chicago, November 15, Knox County Medical Society, in Galesburg, The Basis of Modern Atomic Therapy, illustrated.

Abraham F. Lash, Chicago, November 15, Whiteside-Lee County Medical Societies, Rock Falls, Surgical Geriatric Gynecology, illustrated.

Hugo O. Deuss, Chicago, November 27, De Kalb County Medical Society, in Sycamore, Unusual Diagnostic Chest Problems.

George M. Cummins, Chicago, November 29, Henry County Medical Society, in Kewanee, Some Cardiovascular Aspects of the Aging.

Fletcher Austin, Chicago, December 18, De Kalb County Medical Society, in De Kalb, The Patient With Vertigo.

Walter S. Priest, Chicago, December 19, Du Page County Medical Society, Elmhurst, Use of the Resins in Cardiac Disease, illustrated.

Charles N. Pease, Chicago, December 20, Whiteside-Lee County Medical Societies, Morrison, Fractures of the Long Bones, illustrated.

Edward D. Allen, Chicago, December 20, Stock Yards Branch, Chicago Medical Society, Evangelical Hospital, Chicago, Irregular Vaginal Bleeding at All Ages, illustrated.

Postgraduate Conference in Mount Vernon.—A Postgraduate Conference arranged by the Postgraduate Education Committee of the Illinois State Medical Society, in cooperation with the University of Chicago School of Medicine, was held Thursday, December 6, in Mount Vernon, with the Jefferson-Hamilton County Medical Society acting as host to a complimentary luncheon at the Emmerson Hotel.

The participating physicians, all of Chicago, on the afternoon program which was held at the Mount Vernon Tuberculosis Sanitarium, included George A. Hellmuth, Chairman, Postgraduate Education Committee, presiding; George V. LeRoy, associate dean, Problems in Diagnosis of Coronary Disease, illustrated; Wright Adams, professor and chairman of the department of medicine, Treatment of Congestive Heart Disease, illustrated; Walter L. Palmer, professor of medicine, Management of Peptic Ulcer, illustrated; Mila Pierce, associate professor of pediatrics, Treatment of Anemia in Children, illustrated; M. Edward Davis, professor of obstetrics and gynecology, Management of the Placental Stage and Postpartum Hemorrhage, illustrated; H. Close Hesseltine, professor of obstetrics and gynecology, Common Gynecological Problems, illustrated; Stephen Rothman, professor of dermatology, Neuro-Dermatitis or Atopic Eczema, illustrated; and Henry T. Ricketts, professor of medicine, Diabetes Mellitus, illustrated.

A question and answer period concluded the afternoon session. Burtis E. Montgomery, Harrisburg, Councilor of the Ninth District of the Illinois State Medical Society, presided at the evening session. Following the dinner, Dr. Montgomery discussed Inside the Medical Story; and Lowell T. Coggeshall, dean, division of biological sciences, the evening speaker, presented Military Medical Problems in Korea.

THE FIRST ELECTROCUTION

. . . The year before I resigned marked the first electrocution in the jail, and may I observe that hanging appears to me to be much more humane than electrocution. During a hanging there is motion from the beginning of the march to the end, and therefore, occupation all the time. The walk to the scaffold accompanied by the hymns or the prayers of the clergyman, the quick walk up the steps of the scaffold, the immediate adjustment of the rope, and the signal for the trap to be sprung seem to be all one action and take little time. The fall through the trap and the sudden tightening of the rope must bring about immediate unconsciousness, even if the neck is not broken. About 30 minutes pass after a hanging before the pulse is imperceptible. The electrocution, however, was horrible in comparison to this. The prisoner was led to the chair handcuffed, his elbows to the rear, and a stick placed across his back and protruding from the hollow of each elbow. Arriving at the chair, this paraphernalia was removed by guards and the prisoner was seated. About 5 minutes were required to adjust the straps and the headgear. During this time the hands were opening and shutting and trembling in nervous anticipation. Finally the juice was turned on. The body's muscles contracted and strained on the straps which bound his hands and his feet. He seemed about to break the straps and to stand up. After 30 seconds the juice was turned off and I approached the chair, stood on the rubber mat in front of it and applied my stethoscope. The heart was beating strong and regularly. I stood away, and another dose of electricity was administered—another examination—same result. A third electrical current was passed through the body and smoke and the odor of scorched flesh came from the condemned man's helmet. His heart was examined again and it had ceased to beat. He was dead. *Excerpt: Recollections of Old Gallinger Hospital, James A. Gannon, M.D. Washington, Medical Annals of the D. of C., Aug. 1951.*

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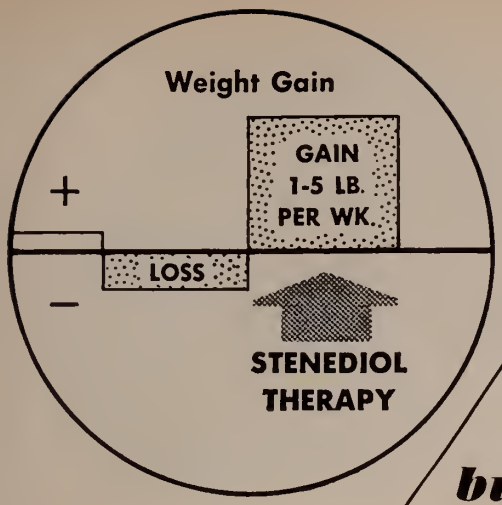
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PHYSICAL MEDICINE ABSTRACTS



PRESENT AND FUTURE PLANS FOR THE REHABILITATION OF PATIENTS IN GENERAL HOSPITALS—II

Nila Kirlpatrick Covalt, M.D., Rocky Hill, Conn. In THE MODERN HOSPITAL, 76:5:96, May 1951.

Physical medicine basically comprises the two divisions of occupational therapy and physical therapy. The minimum equipment and space for physical therapy in any hospital containing up to 300 beds is eight treatment tables in 8 by 8 foot cubicles. Ideally, there should be treatment rooms with a large adjoining gymnasium.

A gymnasium is more important at the start of a program than is the treatment room containing treatment tables and the various modalities used in physical medicine, particularly when no physiatrist is available. Many exercises are best given on mats, where patients can do more exercises with a more nearly complete range of motion and without the fear of falling which they have on a table. Progressive exercises such as crawling or short crutch walking, can be done only on mats.

Functional training in "Activities of Daily Living," walking retraining, and crutch walking are based upon a sound knowledge of kinesiology. This knowledge of muscle action is the basic knowledge for physical therapists particularly, and to only a slightly lesser extent for occupational therapists. Because of this specialized training, it is easier for therapists to retrain patients than it is for individuals without such knowledge to do the training. However, these procedures are not so specific as definitive muscle reeducation and proper choice of many therapeutic exercises which therapists must do. Hence, a physical therapist can teach the principles of crutch walking and functional training to any interested nurse, other hospital personnel, or to relatives. Therapists can also give instruction in correct bed positioning. Lantern slides and movies are available on loan from various sources which show some of the techniques.

If it is impossible for a hospital to hire a qualified physical therapist, there are therapists probably available in most states who can be called in as consultants to help train the hospital personnel. Sometimes therapists are employed in various sections of state departments of health and the state would be willing to loan them.

If it is impossible to complete all training in self-care activities without the use of braces, then they too should be provided. Early bracing and attention to the details of bracing are important aspects of rehabilitation and are the physicians' problems. Training in their use (including putting the braces on and taking them off) are therapists' and nurses' problems. Walking reeducation with prostheses is the therapists' problem.

(Continued on page 46)





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Physical Medicine (Continued)

THE ORTHOPEDIC MANAGEMENT OF ARTHRITIS

Paul C. Colonna, M.D., Philadelphia, Pa. IN THE PENNSYLVANIA MEDICAL JOURNAL, 54:5:-443, May 1951.

In the early stage of arthritis many of the joint deformities can be obviated by careful attention to the sleeping position of the patient, by the use of fracture boards under the mattress, and by stressing better body balance in walking. Simply the weight of the bedclothes is a factor in producing an equinus or drooping of the foot in those patients recumbent much of the time. Allowing the patient to relax in bed in a semi-Fowler position may give rise to hip and knee contractures as well as deformities of the spine. If simple conservative measures are neglected in the early phase, very resistant deformities may be developed later. Measures directed toward better body posture and improvement of local circulation in the impaired joint by the various modalities of physical medicine, stressing the loss of excess body weight and the restriction to weight-bearing when the arthritis involves the lower extremities, are all-important. Non-weight-bearing exercises such as swimming and exercises under the control of the physical therapist can usually be recommended. Splints and braces all have their place in the conservative management.

Fatigue, exposure to damp atmospheric conditions, mental worry, and emotional strain of one sort or another can definitely aggravate the picture, and in the rehabilitation of these patients many factors on a psychosomatic basis must be considered. Rehabilitation always is a slow process and the aim in these patients rarely can be to cure the patient, for in most of them certain irreparable damage has been done to the affected joint or joints. However, the patient can be made more comfortable and able to return to a gainful occupation.

THE PAINFUL BACK

A. W. Bagnall, B.A., M.D., M.R.C.P. (Lond.), F.R.C.P. (C.), Vancouver, B. C. In THE CANADIAN MEDICAL ASSOCIATION JOURNAL, 64:2:107, February 1951.

In most patients with painful backs, psychotherapy must be more practical than intellectual. They get better by feeling better. Non-narcotic anodynes and mild sedation provide the medicinal background but the really important measures are physical therapy and life adjustment. X-ray therapy occasionally is effective after the fashion of a long-lasting anodyne—not for any curative effect on the cause.

Physical therapy is directed to exercises designed to build up the spinal musculature to protect against the ordinary jars of everyday life and to maintain a useful range of motion. Erector spinae muscle weakness is a common cause of back pain and, in itself, produces a feeling of physical inferiority contributing its full share to the symptom complex. With the cooperation of the patient, simple non-weight-bearing exercises taught by a skilled physical therapist can do wonders to bolster flagging morale and adapt the afflicted person to resume a gainful occupation.

Reasons have been given why the clinical and therapeutic approach to the patient with a painful back must be "total" to be successful. An attempt has been made in this discussion to outline some of the mechanisms by which back pain is produced as a result of the strains of living in this highspeed world of today. Two of these pain-producing mechanisms, overactivity of the sympathetic nervous system, and imbalanced function of the pituitary-adrenocortical axis are discussed in more detail.

HEAVY-RESISTANCE EXERCISES: THE "OXFORD TECHNIQUE"

A. N. Zinovieff, D. Phys. Med. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 14:6:129, June 1951.

De Lorme described a system of "heavy resistance — low repetition exercises" to build up power and volume in various muscles, but with particular reference to the quadriceps, as opposed to "low resistance — high repetition exercises" to develop endurance. De Lorme's method was given a trial at the Department of Rehabilitation and Physiotherapy, United Oxford Hospitals, but consistent difficulties were encountered. At each session of exercise, while building up to the 10 R. M., the quadriceps became so fatigued that the last quarter of the session became very exhausting to the patient. In addition, the quality of performance fell off to such an extent that full active extension of the knee was by

(*Continued on page* 48)

In Coronary Atherosclerosis... Morbidity and Mortality can be reduced with

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In a report of a three year study of 115 cases of coronary atherosclerosis, a marked reduction in mortality was noted after prolonged lipotropic therapy as compared to the mortality among an equal number of untreated controls.[1] The efficacy of lipotropic agents in the treatment of coronary atheromatosis may be due to their ability to reduce the serum levels of cholesterol and other lipids which are considered to be of etiologic importance in atherosclerosis.[1, 2, 3]

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H. J. Carr, M.D., Staff Physician.

then rarely possible, thus detracting from the value of the session and preventing the performance of the exact technic.

The Oxford Technic.—The principle of "heavy resistance — low repetition" seemed to have so much to recommend it that it was considered that it should be retained. However, after some consideration, it was decided to reverse the procedure, in order to make it a more physiological method of exercise and yet retain this principle. In other words, after a brief period of warming up the muscle by quadriceps drill and anti-gravity contractions, the exercise period was begun with the 10 R.M., and then the weight was reduced at the end of each group of 10 lifts, 100 lifts constituting a session. In this way it was believed that the fall in resistance could be made to approximate to the fatigue in the muscle, and yet, in each group of 10 lifts, the muscle would be exercised to its maximum of capacity. Obviously, there are many practical difficulties in estimating the rate of fatigue in different individuals, and thus assessing the amount of weight that should, theoretically, be discarded after each group of lifts. It was found after trial, however, that for the quadriceps a reduction of one pound after each group of lifts was a satisfactory average, and this was adopted.

In order to maintain rapid progression, the patient attempted to increase his 10 R.M. by one pound each day, and if he was successful the new 10 R.M. was used as the starting point for the next day's exercise session. If not, no further increase was attempted on successive days until this figure had been achieved. When the 10 R.M. was less than 10 pounds, a proportion of 20 repetitions was included, so as to maintain the lowest weight used as that of the limb plus the weight-holder (4 pounds).

In 55 consecutive out-patient cases with wasted and weak quadriceps muscles, careful records were kept to observe the efficacy of this technic in developing power and volume. Particular attention was paid to complaints of pain on doing these exercises and to the state of effusion, if any. These patients had no other physical therapy than the once-daily session of heavy-resistance exercises 5 days a week. They repre-

(*Continued on page* 52)

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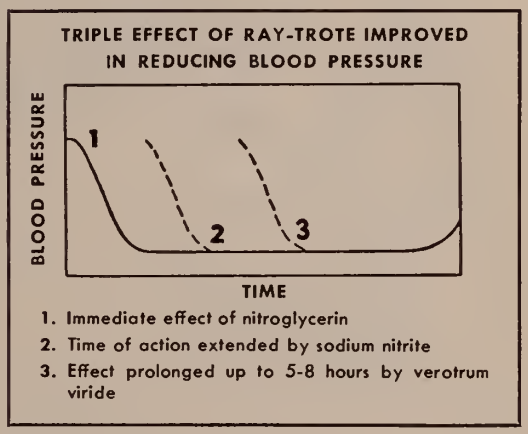
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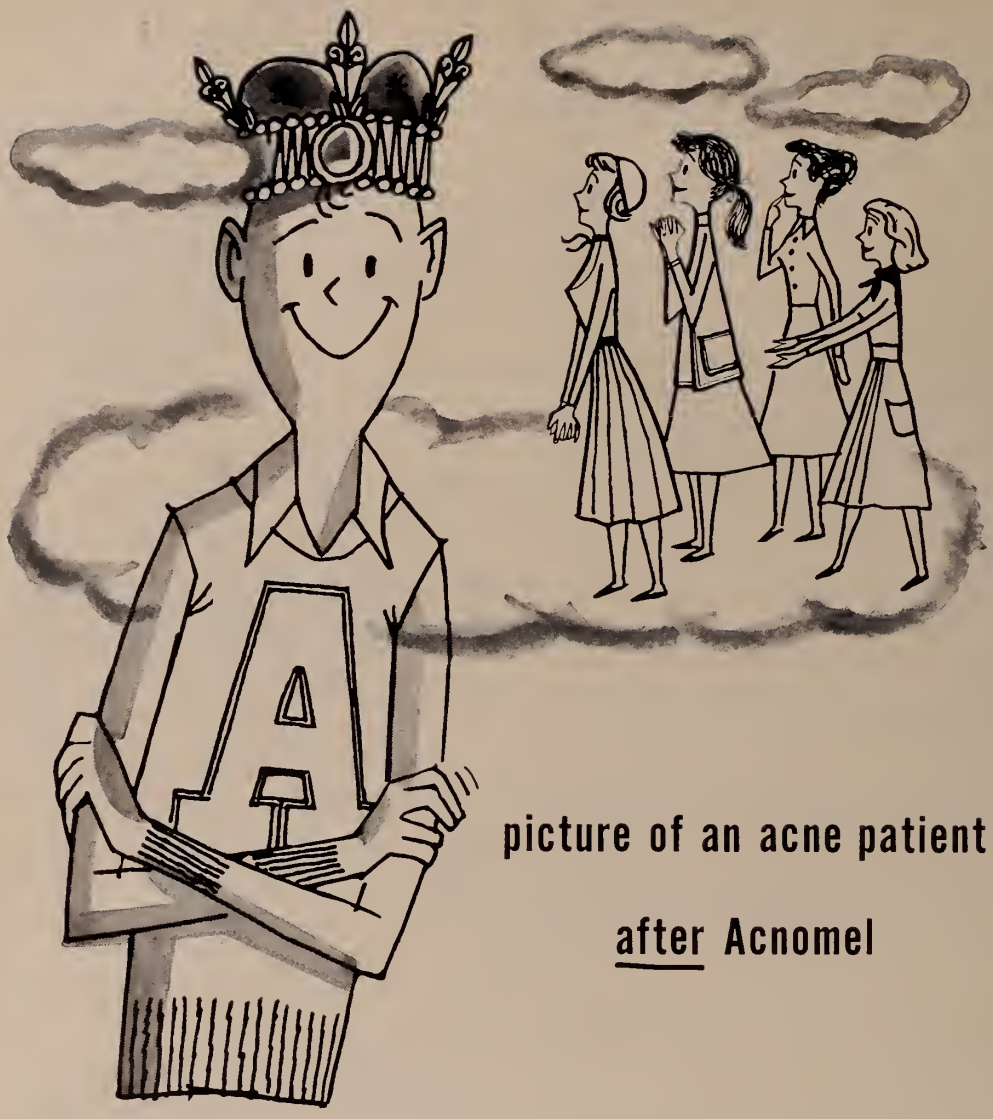
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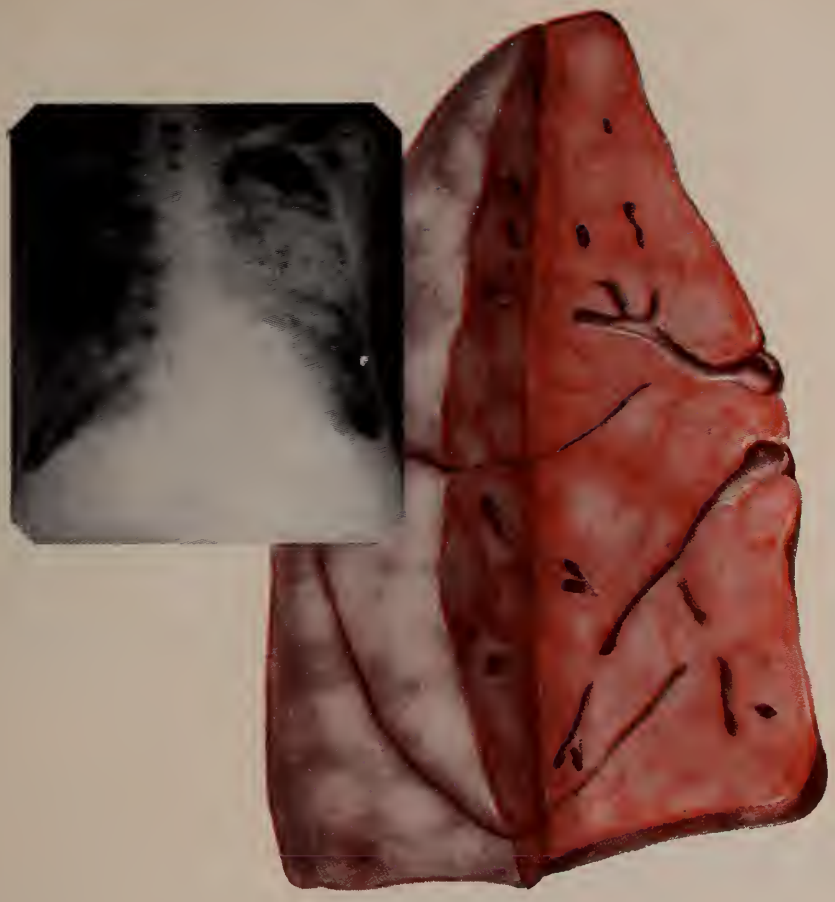
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Potterfield, T. G., and Starkweather, G. A.: J. Philadelphia General Hosp. 2:6 (Jan.) 1951.

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Physical Medicine (Continued)

sented a cross-section of the average type of cases that are treated by the accident service of a big general hospital. Included were cases of traumatic synovitis and rotation strain of the knee, ligament and cartilage tears of the knee, post-meniscectomies, fractured femora, fractured tibiae, and so forth. The series was not considered to be large enough for details case analysis.

Exercises, carried out in the fashion described, resulted in an average volume increase of 3/8 inch every two and one-half weeks. The 10 R.M. increased at just over one pound a day (7 pounds in 5 days), and the absolute power (measured by a single spring lift) increased by 10 pounds a week. An average of just over 2 weeks' treatment was required before discharge with normal or nearly normal power (within 10 pounds S.S.L. of normal quadriceps).

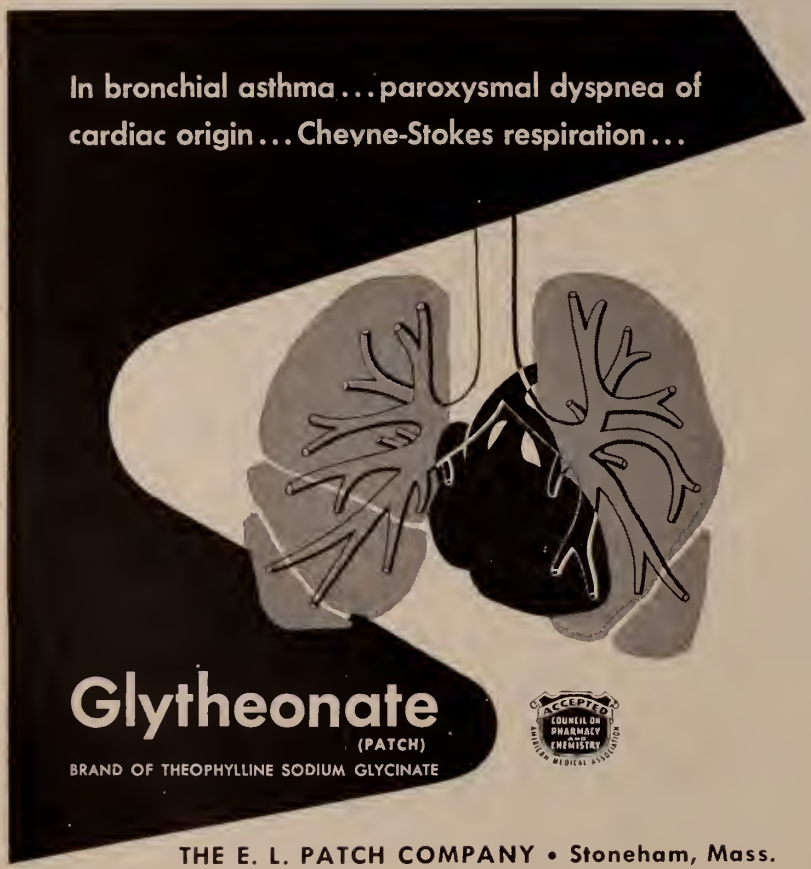
The "Oxford Technic", while retaining the principle of heavy resistance — low repetition, yet allows a longer period of daily exercise, with less strain on the patient or on the patient's knee. For out-patients who are working, it provides a method of developing volume and power in wasted and weak muscles, which takes only about half an hour 5 days a week. If the oriteria for selection of cases are strictly adhered to, neither difficulties nor complications are experienced. It is important to note, however, that attention to detail in performing the exercises is very important in obtaining the best results, and that the daily session must be supervised by a physical therapist or remedial gymnast. As with de Lorme's technic, it has been successfully adopted for use in muscles other than the quadriceps.

THROMBOPHLEBITIS

Jack T. Rush, Lt. Col., M.C., U.S.A. and James H. Forsee, Col., M.C., U.S.A. In UNITED STATES ARMED FORCES MEDICAL JOURNAL, 2:8: 1169, August 1951.

Ninety-nine patients with acute thrombophlebitis occurring in 42,939 admissions were treated with anticoagulants between January 1, 1947,

(*Continued on page* 54)



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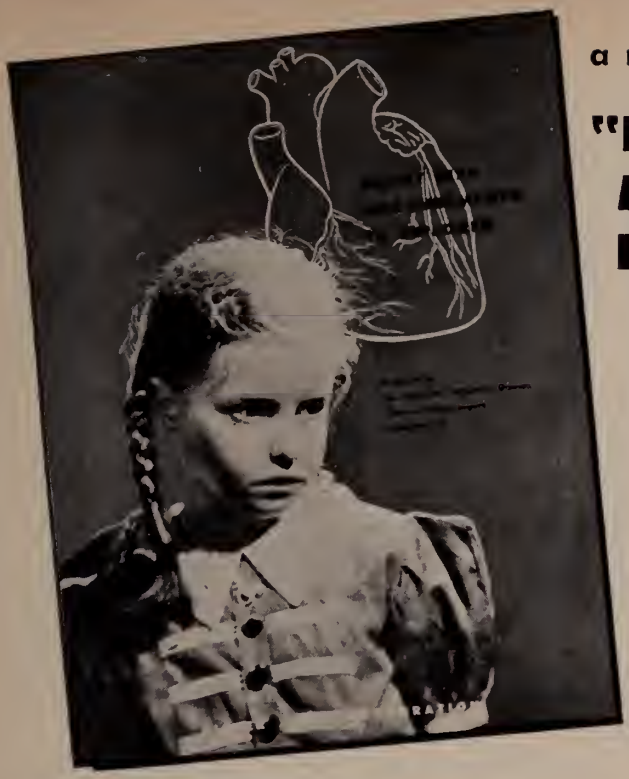
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*Council on Pharmacy & Chemistry: New and Nonofficial Remedies, 1950, Philadelphia, J. B. Lippincott Company, 1950, p. 285.



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Dr. Gomez's work complements two earlier Picker technical texts — *Heart Size Measurements*, and *Roentgenology of the Heart* prepared by the Medical Department of the Equitable Life Assurance Society of the United States. Copies of any or all of them are available on request from the Picker X-Ray Corporation, as a complimentary service.

*Dr. Gonzálo Esguerro Gomez
Clínica de Morly
Bogotá, Colombia, S. A.*



Nomograms for area and transverse diameter of frontal heart silhouette, with Interpretive key. Tables for theoretical transverse diameters for various heights and weights, with chart for determining percentage deviations from average.



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Physical Medicine (Continued)

and December 31, 1949. The results were satisfactory in 97 patients; 2 required inferior vena cava or right common iliac vein ligation to prevent further pulmonary emboli. One 74-year-old patient died of pulmonary emboli, suddenly and without having received anticoagulant therapy following appendectomy. Penicillin is used in the presence of cellulitis. Lumbar sympathetic nerve block has been especially beneficial in relieving arteriospasm. Short wave diathermy is of value in treating the postphlebitis fibrositis. The occurrence of pulmonary emboli can be minimized by meticulous pre- and postoperative care. Patients with pulmonary emboli require immediate therapy. Postphlebitic venostasis has been treated with good symptomatic results by superficial femoral vein ligation combined when indicated with lumbar sympathectomy.

IMMEDIATE TREATMENT OF HAND INJURIES

Sumner L. Koch, M.D., Chicago, Ill. In THE PENNSYLVANIA MEDICAL JOURNAL, 54:8:721, August 1951.

The principles of the immediate treatment of injuries of the hand are identical with those of compound injuries elsewhere, and it is those principles which are stressed rather than specific details. They are stated very briefly as follows, and then Doctor Koch gives a brief elaboration on each principle.

1. Protect the open wound from infection.
2. Stop bleeding.
3. Determine the extent of injury.
4. Transform the contaminated wound into a clean wound.
5. If the latter can be accomplished, bring fractured bone fragments into position, repair the injured structures, and close the wound.
6. If one is uncertain as to the cleanliness of the wound, reduce fractured bone fragments but leave injured tendons and nerves undisturbed, and either leave the wound open or bring wound edges together without tension.
7. Cover the entire injured area with a large compression dressing.
8. Apply a splint to keep the part at rest.

A few words should be added concerning the later treatment of injuries of the hand, after wound healing is complete. If further surgical

(*Continued on page* 56)

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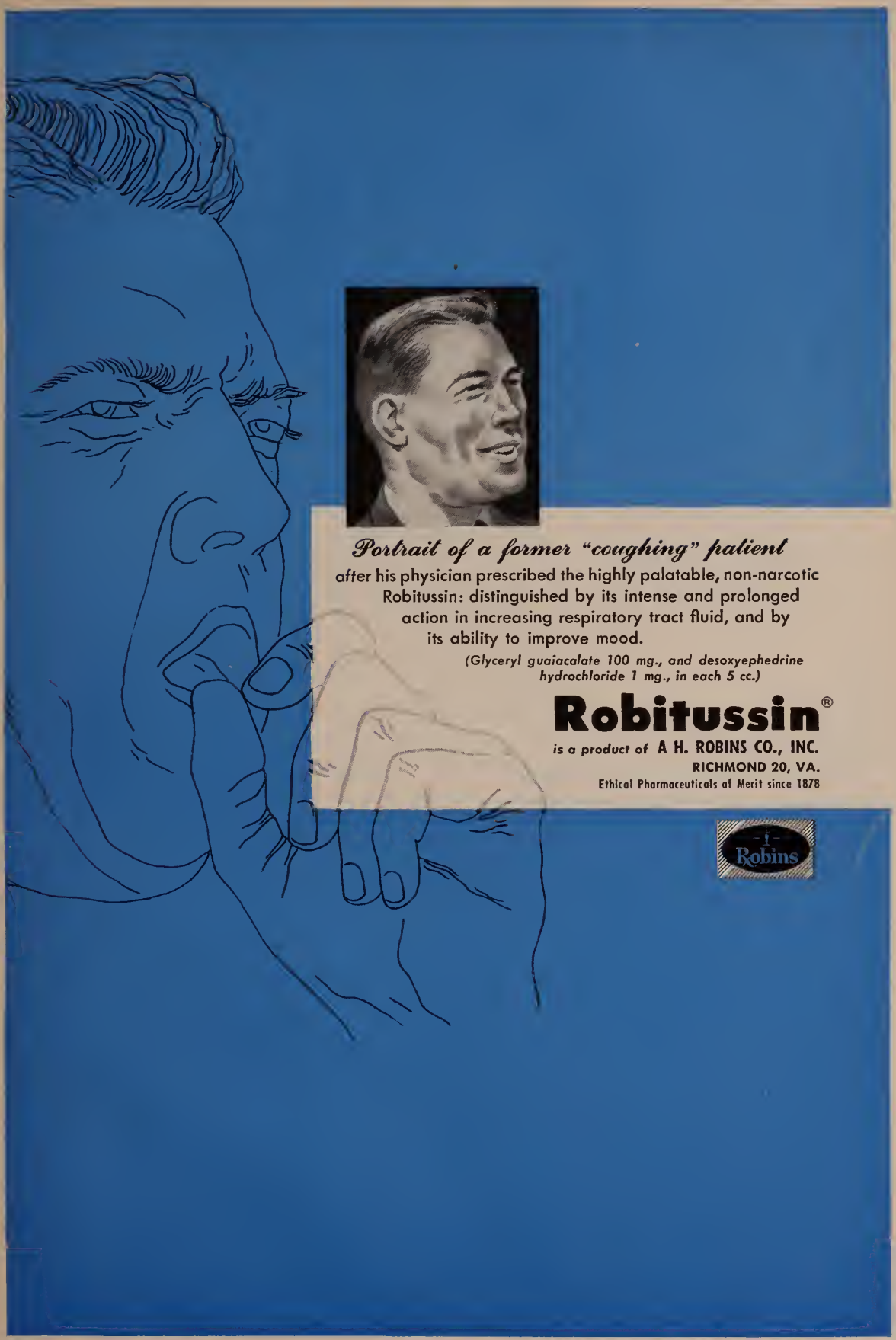
treatment is indicated, it should be delayed until inflammatory reaction and deep induration about the site of injury have subsided. If infection develops after the original injury, bacteria will remain viable in the deeper tissues for a number of weeks after wound healing is complete. Inflammatory reaction persists still longer and makes exposure and mobilization of injured structures tedious and difficult. The best results will be secured if secondary operations are delayed until tissues are as nearly normal as possible.

During the waiting period much can be accomplished by simple physical therapy. One of the most helpful procedures available is to have the patient soak the injured hand for 15 or 20 minutes at least twice daily in warm soapy water, massaging it gently with a soft washcloth during the period of soaking, and to have him move the fingers through as wide a range of movement as possible without producing swelling and pain. To stimulate circulation and so improve the nutrition of the tissues, and to maintain flexibility and increase the range of movement at the small joints of the hand are objectives that should be constantly kept in mind as one awaits the most favorable moment for secondary operation.

TREATMENT OF ACNE

Leon Goldman, Cincinnati, O. In POSTGRADUATE MEDICINE, 9:6:526, June 1951.

Local cleansing and drying measures are continued now in a more regular fashion. The older individual has the responsibility of carrying out these directions by himself or herself. Regular daily ultraviolet therapy may be had at home. This should be supervised by the parent until the youth gets old enough to do it himself. Ultraviolet therapy should be in doses of suberythema and should be discontinued in the presence of irritation. Efforts should be made to prevent the child from going to sleep under the ultraviolet lamp. In the seborrheic patient, therapy with ultraviolet has a good effect. X-ray therapy is reserved for the older youth, for the nodulocystic phases; this form of treatment should be given only by the experienced specialist, and then only as part of a planned regimen, not as the sole therapeutic measure.



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(Continued on page 59)

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BOOK REVIEWS



A Textbook of Medicine. Edited by E. Noble Chamberlain, M.D., M.Sc., F.R.C.P., Senior Lecturer in Medicine, University of Liverpool; Senior Physician, Royal Southern Hospital, Liverpool; Physician in Charge, Medical Unit, Sefton General Hospital, Liverpool. Baltimore: THE WILLIAMS AND WILKINS COMPANY, 1951. 1st Edition, 962 Pages. Price $10.00.

This is a textbook of medicine designed for British medical students. There are 17 medical consultants recruited primarily from Liverpool and London Hospitals.

The book is divided into 14 chapters based, as far as practical upon etiology.

Because of the primary purpose of this book; namely, the education of the British medical student, it naturally will find only a limited audience in this country.

J. W. P.

The Pharmacologic Principles of Medical Practice. By John C. Krantz, Jr. Professor of Pharmacology, School of Medicine, University of Maryland; Secretary of the General Committee of Revision of the United States Pharmacopeia 1940-50 and C. Jelleff Carr, Associate Professor of Pharmacology, School of Medicine, University of Maryland; Auxiliary Member of the Revision Committee of the United States Pharmacopeia 1940-50. Second Edition. Baltimore: THE WILLIAMS & WILKINS COMPANY, 1951. Price $10.00.

As stated in the preface, "The central purpose of the second edition of this treatise is identical with the first edition, namely, to present the pharmacodynamic and pharmacotherapeutic actions of drugs as they are used in the treatment and cure of disease".

The organization of the text is very similar to the 1st edition. Revisions have been made to keep abreast of the many advances made in pharmacology. The chapter on antibiotics includes all of the latest developments grouped under this heading.

The chapters on "The Chemotherapy of Tuberculosis" and the "The Chemotherapy of Rickettsial Diseases" are new. There is a chapter dealing with Antimotion, Sickness Drugs and one on the Adrenal Corticotropic Hormone and Cortisone.

J. W. P.

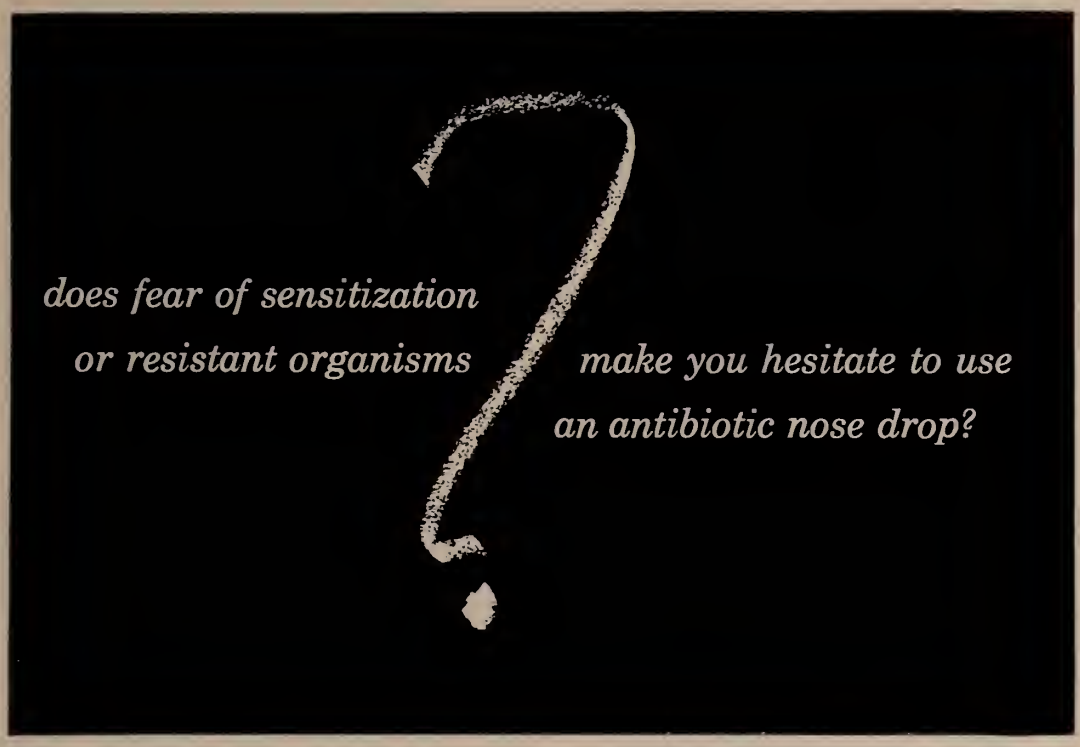
Recent Advances in Nutrition, Paul R. Cannon, Ph.D., M.D., Chairman of the Department of Pathology, University of Chicago. In Collaboration with Earl P. Benditt, M.D.; Laurence E. Frazier, M.A.; Eleanor M. Humphreys, M.D.; Harold C. Steffee, M.D., Ph.D.; Robert W. Wissler, M.D., Ph.D.; Robert Woolridge, M.A. 74 pages, 23 graphs. University of Kansas Press, Price $2.

This excellent book deals primarily with protein and its metabolism in a manner understandable not only to physiological chemists but to physicians, nutritionists, and laymen interested in this subject.

Some of the most important facts disclosed by this review of recent research:

1. That there are eight known Amino Acids necessary in human diet to maintain weight and nitrogen balance, and at least nine essential to most experimental animals.
2. That those essential Amino Acids are not stored in the human or animal bodies as are fats and carbohydrates, therefore, an adequate supply must be ingested daily.
3. That the eight Amino Acids essential to man must be ingested daily in the proper relative proportions since feeding of the daily total requirements sup-

(*Continued on page 62*)



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BOOK REVIEWS (Continued)

plied at different times of the day results in weight loss and disturbance in nitrogen balance.

4. That some energy producing foods, i.e., carbohydrates or fats, must be fed with these Amino Acids to prevent the conversion of a great part of these Amino Acids to glucose instead of being utilized in their original form.
5. That the best proportion of Amino Acids for human and animal substances are derived from muscle and protein in milk.
6. That the proportion of these Amino Acids necessary to humans and animal nutrition may be greatly disturbed by the processing methods used at the present time.

Porter Lectures, Series 14.

L. T. H.

ESSENTIALS OF ORTHOPAEDICS. By Philip Wiles, M.S. (Lond.), F.R.C.S. (Eng.), F.A.C.S. Hon. Orthopaedic Surgeon, Middlesex Hospital and King Edward Memorial Hospital Consulting Orthopaedic Surgeon, Royal Surrey County Hospital. THE BLAKISTON COMPANY, Philadelphia: Toronto, 1949. Price $10.00.

As the title indicates this is a textbook on the essentials of orthopaedics and as such it is excellent. It is not a treatise on the treatment of fractures.

It is well written. The arrangement of material is good. The diagnosis and illustrations have been chosen with care and intelligence. Several color plates have been included. The type and printing make for an extremely readable text.

J. W. P.

PROCEEDINGS OF THE SECOND CLINICAL ACTH CONFERENCE: John R. Mote, M.D., Editor. The Blakiston Company, 1012 Walnut St., Philadelphia 5, 1951. Volume I — Research, $8.50; Volume II — Therapeutics, $8.50.

To evaluate and correlate the tremendous progress in the investigative and therapeutic uses of ATCH over the past 12 months, a Second Clinical Conference was held in Chicago in Dec. 1950. A total of 102 papers were presented. The material is here gathered into two volumes arbitrarily designated "Research" and "Therapeutics". The former contains papers dealing primarily with research at the more fundamental level; the later with the clinical aspects of the problem. Naturally as this phase of medical progress is still membalus, there is some unavoidable overlapping of material in the two volumes.

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J. W. P.

TREATMENT OF THE NEPHROTIC SYNDROME. By Lee E. Farr, M.D., Chairman, Medical Department,

(*Continued on page* 64)



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In its widely distributed leaflet No. 268, "Eat a Good Breakfast," the U. S. Dept. of Agriculture states: "Summer or winter, there's something hot, as a rule, in a good breakfast.... Something hot is cheering and tones up the whole digestive route."

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BOOK REVIEWS (Continued)

Brookhaven National Laboratory, Physician-in-Chief, Brookhaven National Laboratory Hospital, Upton, Long Island, New York, Cloth. $1.75. pp. 61. Charles C. Thomas, Publisher, 301-327 East Lawrence Avenue, Springfield, Illinois, 1951.

This booklet of 61 pages is divided into an Introduction and seven chapters as follows: 1. Treatment of Edema; 2. Treatment of Malnutrition; 3. Treatment of the Renal Lesion; 4. Treatment of Complications; 5. Nephrotic Crises; 6. Cortisone, ACTH and Nitrogen Mustard; 7. General Comments; References. It is especially designed, of course, for internists and pediatricians, all of whom should have it in their library. The tone of it throughout bespeaks a very large experience in this field by its author.

J. H. H.

Researches in Binocular Vision: By Kenneth N. Ogle, Ph.D., Section on Biophysics and Biophysical Research; Research Consultant in the Section on Ophthalmology, Mayo Foundation and Mayo Clinic, Rochester, Minnesota. 345 pages with 182 figures and 26 tables. Philadelphia and London: W. B. Saunders Company, 1950. Price $7.50.

This is a profound presentation of an exhaustive study of a difficult subject. Doctor Ogle analyzes earlier research on binocular vision and integrates the true ideas with his own original contributions.

The book describes researches as follows first, the specific sensorial organization of the two retinas; second, the fusion processes; third, the functional effect of altering the relative magnification of the images of the two eyes; and fourth, the anomalous condition of aniseikonia as a factor in efficient binocular vision and its bearing upon our concepts of the stability of the organization between the two retinas.

The greater part of the subject matter is based upon the researches in binocular vision conducted at the Dartmouth Eye Institute, which terminated its eighteen years of activity on July 1st, 1947. It conducted intensive research on problems in physiologic optics and the application of the results to clinical ophthalmology and to visual science in general.

L. P. A. S.

Physiology of the Eye — Clinical Application: by Francis Heed Adler, M.A., M.D., F.A.C.S.; William F. Norris and George E. de Schweinitz, Professor of Ophthalmology, School of Medicine, University of Pennsylvania, and Consulting Surgeon, Wills Hospital, Philadelphia. 319 illustrations including 2 in color. St. Louis: The C. V. Mosby Company, 1950. Price $12.00.

This book presents ocular physiology as determined in the laboratory and in clinical application. "Clinical Physiology of the Eye" of twenty years ago has been rewritten, rather than revised.

There is a vast amount of new knowledge on this subject and it is from the original literature, some of

(*Continued on page 66*)



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*Perloff, W. H.: Am. J. Obst. & Gynec. **58**:684 (Oct.) 1949

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it as late as 1950, that the author has selected his material. There is a bibliography at the end of each chapter.

This is an excellent book for students and practicing ophthalmologists.

L. P. A. S.

CLINICAL TROPICAL MEDICINE. R. B. H. Gradwohl, M.D., Editor-in-Chief. Luis Benitez Soto, M.D. Oscar Felsenfeld, M.D., Editors. St. Louis, The C. V. Mosby Company, 1951, Price $22.50.

At the outbreak of World War II survey revealed that there were only 24 civilian doctors in the United States available for service with sufficient background to be useful in training medical men in tropical medicine. Yet many of the aspects of tropical medicine are world wide in scope. There has been a tremendous influx of people to temporate zones who have been exposed to tropical diseases such as troops and refugees. Economic reasons become manifest when we view the restrictions of our exports to malarious countries because malaria depresses the economic levels and all our imports from malarious countries carry a hidden "malaria tax". "Clinical Tropical Medicine" is a valuable addition to the armamentarium of physicians who will more and more be confronted with medical problems formerly thought to be restricted to remote geographical areas.

This book has 5 contributors representing some of the leading authorities on tropical medicine. The editors have selected contributors only among those with clinical experience with the diseases with which their writings was concerned.

The book contains 73 chapters, 473 illustrations and 6 color plates. The last 10 chapters deal with hygiene in the tropics, organization of preventative medicine in the tropics, histologic and laboratory technics and other related practical aspects of tropical medicine.

J. W. P.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

DISEASES OF THE EAR, NOSE, AND THROAT — A Textbook of Clinical and Laboratory Procedures. By Georges Portmann, M.D., Professor of Oto-rhino-laryngology at the University of Bordeaux; Dean of the School of Medicine and Pharmacy of the

(*Continued on page* 68)





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BOOKS RECEIVED (Continued)

University of Bordeaux; Surgeon at the Hospital of Tondu, Bordeaux; Surgeon at the Hospital Leopold Bellan, Paris. Translated by Fernand Montreuil, M.D. and Jules G. Waltner, M.D., College of Physicians and Surgeons, Columbia University (New York). The Williams & Wilkins Company, Baltimore, 1951. $20.00.

Clinical Laboratory Diagnosis. By Samuel A. Levinson, M.S., M.D., Ph.D., Director of Laboratories, University of Illinois Research and Educational Hospitals, Chicago, Illinois; Professor of Pathology, University of Illinois College of Medicine, and Robert P. MacFate, Ch.E., M.S., Ph.D., Chief, Bureau of Laboratories, Department of Health of the City of Chicago; Assistant Professor of Pathology, University of Illinois College of Medicine; Formerly Assistant Director of Laboratories, University of Illinois Research and Educational Hospitals, Chicago, Illinois. Fourth Edition. 1146 pages. 221 illustrations and 13 plates, 10 in color. Lea & Febiger, Philadelphia, $12.00.

Clinical Allergy — A Practical Guide to Diagnosis and Treatment. By Samuel J. Taub, M.D., F.A.C.P., Professor of Medicine and Chairman of the Department of Allergic Diseases, the Chicago Medical School; Professor of Medicine, Cook County Graduate School; Attending Physician, Cook County, Columbus, and Mt. Sinai Hospitals. Second Edition. Revised and Reset. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, $4.50.

Surgical Practice of the Lahey Clinic. By Members of the Staff of Lahey Clinic, Boston. 1014 pages, 784 illustrations on 509 figures. Philadelphia and London: W. B. Saunders Company, 1951. $15.00.

Physical Medicine and Rehabilitation for the Clinician: Edited by Frank H. Krusen, M.D., 371 pages with 96 figures and 13 tables. Philadelphia & London: W. B. Saunders Company, 1951. Price $6.50.

Studies in Medicine — A Volume of Papers in Honor of Robert Wood Keeton. Charles C. Thomas, Publisher, Springfield, Illinois, 1951. $8.50.

The Specialties in General Practice: Edited by Russell L. Cecil, M.D., Professor of Clinical Medicine, Emeritus, Cornell University Medical College, New York City. 818 pages with 470 figures. Philadelphia & London: W. B. Saunders Company, 1951. Price $14.50.

Surgical Treatment of the Motor-Skeletal System. Supervising Editor: Frederick W. Bancroft, A.B., M.D., F.A.C.S., Professor of Clinical Surgery, New York Medical College; Associate Editor: Henry C. Marble, A.B., M.D., F.A.C.S., Consultant, formerly Chief of Fracture Service, Massachusetts General Hospital. In Two Parts. Philadelphia and London, J. B. Lippincott Company, 1951. Price for two volumes, $24.00.

The Pathology of Internal Diseases. By William Boyd, M.D., Dipl. Psych. M.R.C.P. (Edin.), F.R.C.P. (Lond.), F.R.C.S. (C) LL.D. (Sack.),

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D. Sc. (Man.), M.D. (Oslo), F.R.S. (C) Professor of Pathology and Bacteriology in the University of Toronto, Canada. Fifth Edition. 866 pages. 391 illustrations and 11 plates in color. Lea & Febiger, Philadelphia, July 1950. $11.00.

MANAGEMENT OF UREMIA

Restriction of water and electrolytes are imperative in the treatment of acute anuric uremia. Clinical judgment and laboratory technics should control water and electrolyte balance if the kidneys are unable to do so, as in the diuretic phase of acute uremia and in many cases of chronic uremia.

The forced high caloric low protein diet (Borst) prolongs life in cases of acute uremia and in addition may make life worth living in chronic uremia. Artificial kidney and peritoneal lavage may help a patient through an acute phase of the disease toward recovery or in chronic cases may restore the patient's nitrogen equilibrium. Intestinal dialysis employing the entire tract appeared difficult and exhausting to patients in severe clinical condition. Dialysis through an isolated loop offers a chance to those patients with chronic uremia to whom we can offer nothing else. Replacement transfusions are useful in the restoration of hemoglobin but cumbersome when utilized to combat uremia. Makrodex is preferred over other blood substitutes if hypotension has to be treated in patients with uremia. *Excerpt: Treatment of Uremia, W. J. Kolff, M.D., Research Division, Cleveland Clinic Quarterly, July, 1951.*

EVALUATION OF SYMPTOMATOLOGY

It has already been stated that in the New Orleans area 10 per cent or more of the population carry E. histolytica. This incidence has been estimated as low as 4 per cent in some other groups in this country. Such estimates mean that of the individuals with other diseases such as peptic ulcer, carcinoma of the colon, inguinal hernia, and so on, certain ones will be found to have amebiasis. When the symptoms are referred to the colon there is a great likelihood that there is an association between the symptoms and the presence of E. histolytica. However, there is always the possibility that the patient may have some other explanation for the symp-

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toms. For example, we have found patients with virus hepatitis to have amebae in the stools. Another example is one of the patients whom we saw recently. He complained of occasionally loose stools with some admixture of blood. Examination of the stools showed E. histolytica. Microscopically no blood was seen at the time. Proctoscopic examination disclosed no lesions, but from above the end of the scope a small amount of bloody mucoid material was exuding. When this material was aspirated and inspected under the microscope, many red blood cells and many neutrophilic leukocytes were found. The character of this exudate is not of the type seen in amebic infections, and this point led us to the assumption that some other disease was present. Barium enema examination disclosed carcinoma at the splenic flexure. *Excerpt: Some of Amebiasis, William A. Sodeman, M.D., Medical Annals of the D. of C., Aug. 1951.*

Clinical medicine sees the causes of tuberculosis in the bacillus; but social medicine sees the cause of the bacillus in poor living and habitation. John J. Sutter, M.D., The Ohio State Med. J., June, 1951.

POTASSIUM DEFICIENCY

The principal indications for potassium therapy fall into three categories, the most important of which is the actual demonstration of potassium deficiency. Weakness, aphonia, abdominal distention, and increased irritability, or any combination of these symptoms, along with appropriate electrocardiographic findings in those situations predisposing to hypopotassemia should suggest that diagnosis and constitute an indication for potassium replacement.

The continued loss of abnormally large quantities of gastrointestinal fluids whether by vomiting, prolonged gastrointestinal suction, drainage from intestinal fistulae, or diarrhea constitutes a second major indication for potassium therapy. The presence of duodenal ulcer with obstruction, paralytic ileus, or intestinal obstruction requires special attention. Greater potassium loss usually occurs in those cases in which long intestinal tubes are used than in those employing gastric suction.

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prolonged suction may not be anticipated, the magnitude of certain procedures may so disrupt potassium metabolism that large quantities are lost in the urine. In those instances, therefore, the administration of potassium should be included as a part of the preoperative preparation and postoperative care. *Excerpt: Practical Aspects of Potassium Therapy in the Surgical Patient, Edwin H. Ellison, M.D., Thomas W. Morgan, M.D., and Robert M. Zollinger, M.D., Columbus, O., O. State M. J., Sept.* 1951.

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The Red Cross has a far-reaching effect upon the life of every American, especially during these uncertain times. Let's do our part to keep the services of the Red Cross geared to meet the needs of the nation and all its citizens. Answer the call of the Red Cross today so that Red Cross can answer the call of Americans tomorrow.

Despite the encouraging decline of the death rate, and new techniques which should be helpful in the future, tuberculosis is still one of the most important public health problems. It will take many years of undiminished energy to reduce it to an unimportant level. James E. Perkins, M.D., Tr. 1950 Conf. Pub. Health A. New York City.

Obviously, an abnormal finding in the initial X-ray film cannot by itself constitute a clinical diagnosis (of tuberculosis). Nevertheless, it does serve to focus attention on those persons in need of further study. At the same time, such a photofluorographic finding imposes an obligation on the physician and the official health agency — an obligation to carry out full diagnostic study promptly in order to determine the clinical significance of the suspected abnormality. For, the abnormal findings discernible in an initial screening film can range all the way from minor deviations requiring no follow-up or care to some very serious conditions which demand immediate medical attention. David Reisner, M.D. and Arthur Rikli, M.D., Pub. Health Reports, April 6, 1951.

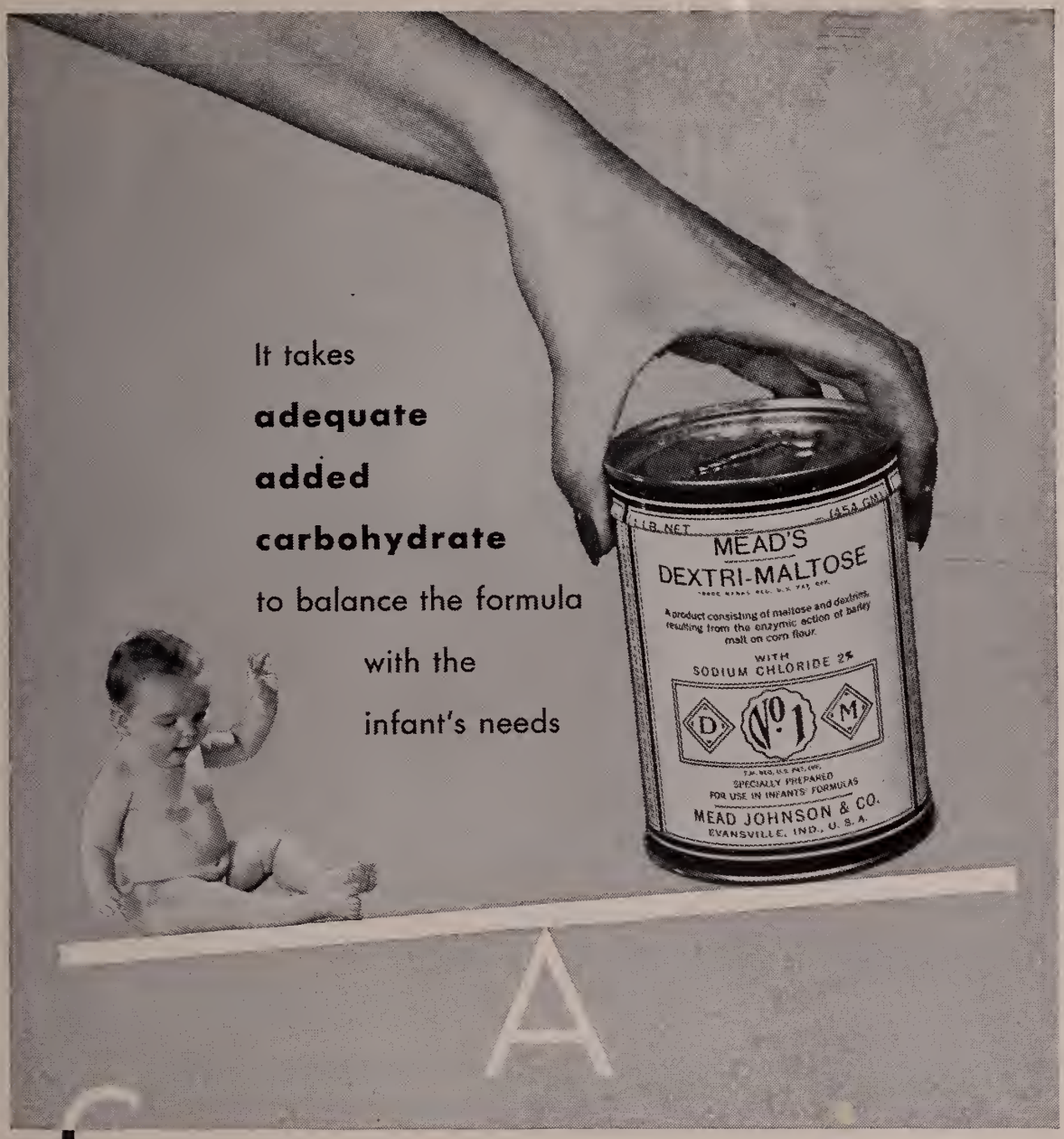
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